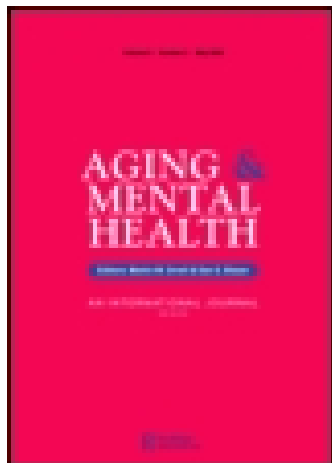


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Implementing living room theatre activities for people with dementia on nursing home wards: a process evaluation study

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Objectives: A new communication method, the 'Veder Method', was implemented in the Netherlands. This method uses theatrical stimuli in combination with proven person-centred communication methods. Care staff was trained to apply the Veder Method in a 'living room theatre activity' for people with dementia. This study evaluates the implementation of the Veder Method on psychogeriatric nursing home wards.

Methods: Facilitators and barriers to train staff and implement the Veder Method in psychogeriatric nursing homes were identified by conducting semi-structured interviews with 12 stakeholders who were involved in the implementation, and five focus groups with 35 trained care staff. The interviews and focus groups were transcribed verbatim, and two independent researchers analysed the content of the transcripts. The Implementation Process Evaluation (IPE) Framework was used to categorize the data and the 7s-model to contextualize the qualitative findings.

Results: A structured overview of facilitators and barriers in different stages of the implementation process is presented. Positive reactions in residents and more reciprocity in caregiver-resident contact motivated trained care staff to work with the Veder Method. An action plan, executive support, the visibility of the method in the organization and a pioneer group that initiated implementation were essential for successful implementation. High work pressure for the care staff was a hindering factor.

Conclusion: Respondents experienced the added value of the Veder Method. The facilitators and barriers to implementation we identified in this study can help to implement and disseminate the successful Veder Method and other person-centred communication methods in psychogeriatric nursing homes effectively.

Keywords: dementia; psychosocial intervention; nursing homes; care staff training; interventions; implementation

Introduction

In the past decade, many person-centred communication methods have been developed with the aim to improve communication between care staff and people with dementia by tailoring it to the subjective needs, wishes and experiences of the people with dementia (Van Mierlo, Van der Roest, Meiland, & Dröes, 2010; Vasse, Vernooij-Dassen, Spijker, Rikkert, & Koopmans, 2010). These person-centred communication methods, sometimes referred to as 'emotion-oriented care' include, for example, Snoezelen[®] (Finnema et al., 2005; van Weert, van Dulmen, Spreeuwenberg, Bensing, & Ribbe, 2005; van Weert, van Dulmen, Spreeuwenberg, Ribbe, & Bensing, 2005), psychomotor therapy (Hopman-Rock, Staats, Tak, & Dröes, 1999), reminiscence (Woods, Spector, Jones, Orrell, & Davies, 2005) and music therapy (Van Mierlo et al., 2010). There is growing evidence on person-centred communication methods improving behaviour, mood and quality of life of people with dementia. But studies on how to implement these interventions in practice are scarce, resulting in a limited dissemination of effective interventions (Moniz-Cook, Vernooij-Dassen, Woods, Orrell, & Interdem Network, 2011; Orrell, 2012). It is crucial to understand whether the implementation went according to plan and achieved the desired results in order to draw correct conclusions about effects of staff training and implementation.

Implementation of care innovations is not always a matter of course. Often, insight into the so-called implementation black box is lacking, i.e. it is not clear which strategy works for whom in which context (Burgio et al., 2001). One review on successful implementation of psychosocial interventions in dementia care pointed out that post-implementation sustainability is given little consideration in implementation studies (Boersma, van Weert, Lakkerveld, & Dröes, 2014). Often, implementation strategies focus mainly on training staff and less on taking measures to safeguard sustainability. Multifaceted strategies that take into account facilitators and barriers to implementation are expected to be the most effective (Wensing, Laurant, Hulscher, & Grol, 1999). This study aimed to gain insight into facilitators and barriers to training staff and implementing a new communication method in regular nursing home care: the Veder Method.

The Veder Method was developed by a theatre group whose artistic director has a background as a nurse (Foundation Theater Veder). The Veder Method uses theatrical stimuli like songs and poetry in combination with elements from successful person-centred communication methods in psychogeriatric care, such as reminiscence (Woods et al., 2005), Validation Method[®] (Feil & Altman, 2004) and NeuroLinguistic Programming (Bandler & Grinder, 1975). Although these methods are well known and frequently

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used in dementia care, scientific studies on their effectiveness show mostly small to moderate effects. Integration of successful elements of these different methods, while combining them with theatrical stimuli, was expected to increase the effectiveness, compared to using the approaches separately. The Veder Method can be applied in 24-hour care as well as in a group activity on nursing home wards, the so-called living room theatre activity. The living room theatre activity can be offered by professional actors, but also by care staff trained in the Veder Method. The goal of the Veder Method is to improve the reciprocity in the interaction between care staff and people with dementia, in order to positively influence behaviour, mood and quality of life of people with dementia and to enhance the work satisfaction of paid care staff (from now, care staff). Over the past four years, the living room theatre activities according to the Veder Method have been implemented on a large scale in Dutch nursing homes. A total of 1150 care staff members on 160 wards were trained to offer the living room theatre activity. A controlled effect study conducted recently showed that living room theatre activities offered by actors had positive effects on behaviour, mood and quality of life of residents with dementia compared to residents who participated in a regular reminiscence group activity (van Dijk, van Weert, & Dröes, 2012). In this paper, we report on a process analysis that was conducted in psychogeriatric nursing homes to evaluate the implementation of living room theatre activities carried out by care staff. By means of a structured process evaluation, it is possible to investigate whether the implementation of an innovation went according to plan, which aspects of the intervention were successfully implemented or not, why implementation succeeded or not and how the results of an effect study should be interpreted (Burgio et al., 2001; Schrijnemaekers, van, van Heusden, Widdershoven, 2002; Philips & van Ort, 1995). Based on the existing literature, we developed a theoretical framework, called the Implementation Process Evaluation (IPE) Framework, to guide the process evaluation in our study. The results of this study may contribute to improving the implementation of the Veder Method and similar effective interventions in regular dementia care.

Methods

Setting

Approval for the study was obtained from the Medical Ethical Committee of VU University Medical Centre in Amsterdam and supplemented by local feasibility statements from the boards of directors of the participating nursing homes.

The intervention: living room theatre activity

A living room theatre activity according to the Veder Method follows a fixed sequence, beginning with (1) one-to-one contact to welcome the persons into the group, (2) activating the long-term memory by offering stimuli that refer to the past, (3) taking a break, (4) activating the short-term memory and (5) closing with individual

contact to say goodbye. A living room theatre activity has a central theme, and every caregiver/actor plays a role that refers to this theme. Costumes, props and recognizable characters are used to create a stage set. Songs and poems are used as well as objects, smells and flavours that refer to the central theme.

Implementation of the Veder Method

The Veder Method was implemented on psychogeriatric nursing home wards (from now, psychogeriatric wards). The training of care staff consisted of three steps: (1) Observing, (2) Learning and (3) Performing. For a description of these steps, see Figure 1. During on-the-job coaching sessions (Step 3), the trained care staff applied the Veder Method in a living room theatre activity for residents and received feedback afterwards from a coach from Theater Veder on (1) the quality of personal contact, (2) how the residents' long-term and the short-term memory were activated, (3) the theatrical elements used, (4) reactions of residents and (5) how the activity was concluded. In order to support further implementation, Theater Veder also organized 'refresher days' (three times a year) that focused on the exchange and transfer of knowledge to and between trained care staff, as well as practical theatre and communication exercises. Also, monthly consultation meetings were organized per city for coordinators in the implementation of the Veder Method in the nursing home groups. These meetings were meant to exchange information and 'best practices' to facilitate implementation. Finally, a symposium was organized every two years for the purpose of sharing experiences, creating a solid foundation for the method and transferring knowledge.

Model for the evaluation of the implementation process

To guide the data collection and analyses for the process evaluation, we used an extended version of the theoretical framework that was developed by Meiland, Dröes, De Lange, & Vernooij-Dassen (2004) to identify facilitating and impeding factors in implementation (Meiland et al., 2004). The framework distinguishes (1) existing conditions that influence the implementation process (factors that are already present at the start of the implementation), and (2) factors that influence the preparation, execution or continuation phase of implementation. The framework of Meiland et al. (2004) is based on a survey of the implementation literature and consultation of implementation experts, and was first applied in a study into the implementation of the Meeting Centres Support Programme for community-dwelling people with dementia and their carers in outpatient care settings (Meiland, Dröes, Lange, & Vernooij-Dassen, 2005). To achieve a model suitable for the nursing home setting of our study, we integrated McKinsey's 7s-model (Peters & Waterman, 2004) in the framework of Meiland et al. The 7s-model, which describes seven factors (all beginning with 'S') that are important in effective organizations, has been successfully applied in a study of the implementation of integrated

Basic principles of staff training to use the Veder Method	
1. <i>Observing</i>	<p>What? Nurses participate together with people with dementia in a living room theatre activity and/or theatre performance offered by professional actors.</p> <p>Setting: Psychogeriatric nursing home ward and/or local theatre.</p> <p>Goal: Nurses experience and observe how professional actors use the Veder Method as a person-centred communication method.</p>
2. <i>Learning</i>	<p>What? Nurses receive a one-day course on the basic principles of the Veder method, i.e. Validation®, reminiscence, emotion-oriented care, NLP, reciprocity. The training consists of offering information, sharing experiences, and exercises on how to enhance reciprocity in communication, practicing basic theatre skills and 5-minute performance.</p> <p>Setting: Group training</p> <p>Goal: Nurses learn about/use the basic principles of the Veder Method.</p>
3. <i>Performing</i>	<p>What? Nurses prepare and execute two living room theatre activities according to the Veder Method. They receive feedback by a professional actor (coaching on the job, see text for further explanation).</p> <p>Setting: Living room of a psychogeriatric nursing home ward</p> <p>Goal: Nurses develop and enhance their skills to apply the Veder Method in a living room theatre activity for people with dementia.</p>

Figure 1. Overview of the three training steps to learn care staff applying the Veder Method in living room theatre activities.

emotion-oriented care in nursing homes (van der Kooij, 2003). The model is based on the assumption that productive change depends not only on the *structure* of the organization or the implementation *strategy*, but also on an interplay between Strategy, Structure, Systems, Style, Staff, Skills and Shared values (see Figure 2 for definitions of the 7s-factors). The integrated model, called the 'Implementation Process Evaluation Framework' (IPE Framework; Figure 3), was the theoretical framework of this process evaluation study.

Participants

Data collection consisted of (1) semi-structured interviews with stakeholders involved in the implementation and (2) focus groups with care staff who were trained to apply the Veder Method. The individual interviews were carried out first, making it possible to use interview data to structure the focus group discussion guide.

- (1) Semi-structured interviews: stakeholders were selected by means of 'purposive sampling' (Barbour 1999): a varied group of people who were involved during the preparation, execution and/or continuation phase of the implementation, and who had insight into the factors that either impeded or facilitated the implementation, were selected. A total of 12 stakeholders were interviewed. Stakeholders were staff members of Theater Veder Foundation ($n = 2$) and a trainer/actor of Theater Veder ($n = 1$), initiators of the implementation/regional director of a participating nursing home group (in this document 'care home group director', $n = 2$), team managers of a participating care home group ($n = 2$), and nursing

assistants ($n = 2$), activity therapists ($n = 2$) and a volunteer ($n = 1$), who had all received training and on-the-job coaching.

- (2) Focus groups: five focus groups were organized, with a total of 35 trained professional caregivers from 21 different nursing homes in order to evaluate how care staff experienced the training and to discuss facilitators and barriers to implementation of the Veder Method. The majority (57%) of the focus group participants were activity therapists ($n = 20$), followed by nursing assistants ($n = 6$) and staff members daytime activities ($n = 3$), a student coach, a staff member 'communication and culture' (responsible for cultural projects in the nursing home group), a receptionist, a nursing home hostess, a volunteer and a staff member 'well-being and relaxation' (similar to activity therapist). For demographics of focus group participants, see Table 1. Of the participants, 94.3% ($n = 33$) had received training and 94.3% ($n = 33$) had also received on-the-job coaching. Many of these people ($n = 29$) still attended the refresher days of Theater Veder. The participants were from nursing homes where implementation started 2–3 years earlier. The focus groups with the care staff who attended the refresher days were organized during these refresher days. A fifth focus group was conducted with care staff who no longer attended the refresher days ($n = 6$), because we assumed that these persons could provide additional insight into implementation barriers. A criterion for selecting the latter care staff was that they were from six different nursing homes. They were asked individually to participate in a focus group.

7s-factor	Definition
Structure	The way in which the organization is structured (e.g. centralized versus decentralized, division of tasks)
Strategy	'Those actions that a company plans in response to or anticipation of changes'
Systems	Refers to all the formal and informal procedures of an organisation (e.g. information, communication and evaluation systems).
Style	Refers to the patterns of action of top-management (e.g. the leadership style).
Staff	Comprehends both the hard aspects regarding staff (e.g. pay scales) and soft aspects (e.g. morale, attitude, motivation and behaviour).
Skills	The dominating attributes or capabilities that makes an organisation successful. For change, it might be necessary to substitute an old skill for a new skill by e.g. training or re-education.
Shared values or superordinate goals	The guiding concepts and fundamental ideas of an organisation. 'The drive for their accomplishment can pull an organisation together'. The ideas to which the organisation, including its staff, is dedicated.

Figure 2. Definitions of the 7s-factors of the 7s-model of Peters and Waterman (Berkhout et al., 2009; Peters & Waterman, 2004).

Procedures

We used qualitative research methods, as these are suitable to study relatively unknown process characteristics. The independent status of the researchers (not affiliated with Theater Veder) and the guarantee of anonymity were emphasized. The IPE Framework that was developed to identify facilitating and impeding factors for implementation formed the basis for the topic guide for the interviews with different stakeholders and the selected topics for each interviewee. Four interviews were held with pairs of interviewees, because the interviewees preferred it that way, and four interviews were conducted individually. The interviews were conducted by a researcher (FT or MVH). Questions that were asked were, for example, 'how were the living room theatre activities implemented?' and 'what were barriers to implementation?' The focus groups were specifically intended to investigate the applicability of the Veder Method on psychogeriatric wards. The researcher (MHD) acted as a moderator, and a research assistant (PG) as an observer. The moderator used a topic guide for the focus groups. The participants were first requested to write down on a paper their personal

reaction to statements addressing the topic. In this way, they had the opportunity to formulate their own opinion first. This was followed by a group discussion. A statement was, for example, 'I am good at applying the Veder Method in a living room theatre activity'. The focus groups lasted between 60 and 90 minutes. As no new aspects were presented to add to the theoretical framework during the last interviews and focus groups, the researchers concluded that saturation had been reached, and no extra interviews and focus groups were needed (Giacomini & Cook, 2000; Tong, Sainsbury, & Craig, 2007). All interviews and focus groups were audio- or video-taped and subsequently transcribed verbatim.

Analysis

First of all, close reading and re-reading of the interview transcripts took place to familiarize ourselves with the data. Subsequently, all verbatim transcripts of stakeholder interviews and focus groups were analysed and categorized on text fragments. A deductive method of data analysis was used: the data were coded based on a predetermined analysis scheme consisting of 28

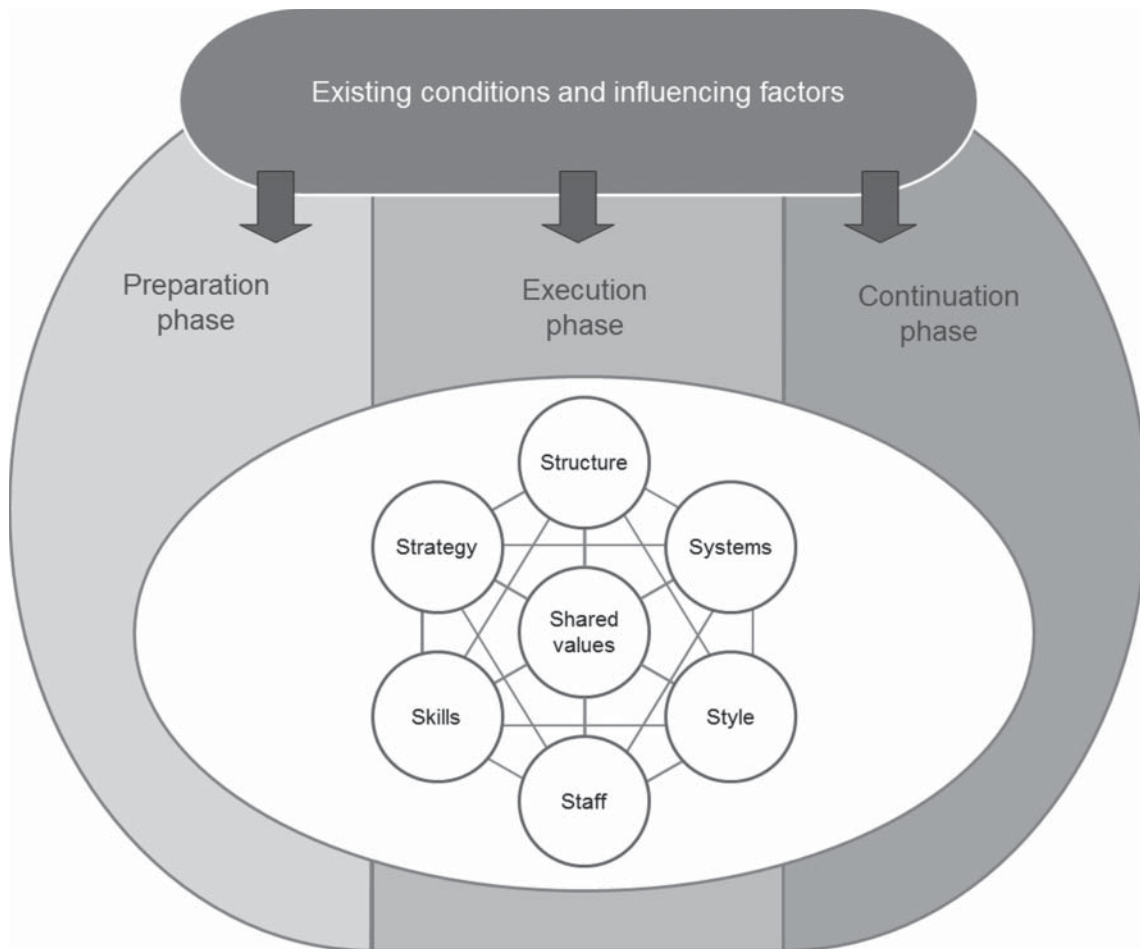


Figure 3. Implementation Process Evaluation (IPE) Framework.

categories derived from the IPE Framework. The IPE framework was used to categorize the data and the 7s-model served as a way to contextualize the findings. This method structured the analyses and increased reproducibility of the study. For the analysis, text fragments about the same theme were classed as ‘meaning units’. These meaning units were coded using the analysis scheme (Graneheim & Lundman, 2004). If no suitable code was available in the analysis scheme, the coders created a new code

Table 1. Demographic characteristics of focus group participants ($n = 35$).

Characteristic	Value
Age, years (SD)	46.0 (12.0)
Female, n (%)	33 (94.3)
Ethnicity	
Dutch, n (%)	30 (90.9)
Other western, n (%)	1 (3.0)
Other non-western, n (%)	2 (6.1)
Education	
Primary school, n (%)	0
Low, n (%)	2 (6.1)
Middle–high, n (%)	20 (60.6)
High, n (%)	11 (33.3)
Work in psychogeriatric care, years (SD)	12.6 (16.9)

(inductive method). To ensure reliability of the results, two researchers (FT and MVH) coded six of the eight interviews independently. When assessors disagreed, or codes were unclear, discussion continued until consensus was reached. The final two interviews were analysed by one assessor (MVH). In cases of doubt, an independent assessor (JW) was consulted to validate the analysis. All focus groups were coded independently by two researchers (PG and MVH) and then discussed. In cases of doubt a third assessor (JW) was consulted. All texts fragments and codes were entered into the qualitative computer software program NUD*ISTVivo (NVivo, 1999). Subsequently, all text fragments were analysed per (sub) category. These analyses and results were discussed extensively in the project group by five members (MHD, JW, RMD, PG, SH). In the ‘Results’ section, quotations that reflect responses given by interviewees illustrate the results. The quotations are coded based on respondent number (RESP), profession (e.g. activity therapist), nursing home number (NH) and type of interview: focus group (FG) vs. interview (INT).

Results

Table 2 shows the existing conditions (factors that were present at the start of the project) that facilitated or impeded the transition from the start of, and throughout,

Table 2. Implementation Process Evaluation (IPE) Framework with facilitating (white) and impeding (grey) factors for implementation of the Veder Method on psychogeriatric wards, categorized per implementation phase and the seven factors of the 7s-model.

	Existing conditions	Preparation phase	Execution phase	Continuation phase
Structure	Facilitating	<ul style="list-style-type: none"> Enthusiastic pioneer group 	<ul style="list-style-type: none"> Support from management* Ensure practical conditions are met* Fixed frequency living room theatre activities* 	<ul style="list-style-type: none"> Core group Ensure practical conditions are met* Fixed frequency living room theatre activities Include application of VM in policy* Lack of support from management Conditions hard to achieve
	Impeding			
Strategy	Facilitating	<ul style="list-style-type: none"> 3-year funding for implementing VM Visibility of VM in organization Involvement of all management levels 	<ul style="list-style-type: none"> Implementation plan Living room theatre activities by actors* 	<ul style="list-style-type: none"> Re-education by means of coaching on the job Positive outcomes scientific research Structural funding
	Impeding	<ul style="list-style-type: none"> Lack of time and money* Staff shortages* Other innovations being implemented at the same time Changing laws and regulations 	<ul style="list-style-type: none"> Lack of implementation plan 	<ul style="list-style-type: none"> No structural funding
Systems	Facilitating	<ul style="list-style-type: none"> Communicating mutual expectations Theater Veder and care home group Fixed contact persons 	<ul style="list-style-type: none"> Visibility VM in nursing home (group) Continue to discuss why VM should be continued to be used 	<ul style="list-style-type: none"> Digital exchange of ideas/experiences Practical manual Active PR-policy Theater Veder
	Impeding	<ul style="list-style-type: none"> Not communicating mutual expectations Theater Veder and care home group* 		
Style	Facilitating		<ul style="list-style-type: none"> Support of management* 	<ul style="list-style-type: none"> Support management
	Impeding			
Staff	Facilitating	<ul style="list-style-type: none"> VM can be used by all staff members 	<ul style="list-style-type: none"> Staff enthusiasm* Visible effects in residents* Contact between colleagues 	<ul style="list-style-type: none"> High work pressure Training of nursing staff focused mainly on physical care*
	Impeding	<ul style="list-style-type: none"> Critical attitude colleagues 	<ul style="list-style-type: none"> Unclear what (acting) level is expected* Key persons left due to staff turnover 	

(continued)

Table 2. (Continued)

	Existing conditions	Preparation phase	Execution phase	Continuation phase
Skills	<ul style="list-style-type: none"> • Experience with person-centred care* • Expected gain in terms of time* 	<ul style="list-style-type: none"> • Training in VM (in courses and on the job) • Certified trainers with background in health care and theatre* 	<ul style="list-style-type: none"> • Continue to use VM • Give staff freedom in how to apply VM* • Staff feels qualities are validated • Insufficient training* 	
Shared values	<ul style="list-style-type: none"> • Insufficient training 	<ul style="list-style-type: none"> • VM is innovative* • VM consistent with current care goals* 	<ul style="list-style-type: none"> • Exchange of tips and experiences during refresher days 	
	Impeding	Impeding	<ul style="list-style-type: none"> • Limited management awareness of surplus value VM • Ethical concerns* 	

Note: *Further explanation is offered in the 'Results' section. Abbreviations: VM = Veder Method.

the implementation process. Also facilitators and barriers affecting the preparation, execution and continuation phases are shown in Table 2. The facilitating and impeding factors are categorized according to the IPE Framework. When necessary, these factors are further explained in the text with the 7s-factor in brackets and in *italics* (indicated by an asterisk (*)) in Table 2).

Existing conditions

Most interviewees viewed the Veder Method as a new method that distinguishes itself from already existing methods, like Validation[®] and reminiscence, by offering a clear structure for establishing contact with residents with dementia. The theatrical stimuli helped them to recall long-term memories and to establish contact here and now. The Veder Method was considered highly compatible with the most central value in the nursing home setting, i.e. providing optimal care and assistance to people with dementia (*Shared values*). Managers and care staff expected gains in terms of 'care time', thanks to improved communication between the residents and care staff (*Skills*).

... then it is very economic. If people feel more comfortable with you as caregiver, it will be easier for example to bathe them, or let them eat, because they offer less resistance. [RESP4, nurse assistant, NH20, INT]

The expected and experienced added value of the Veder Method increased care staff's willingness and efforts to implement the Veder Method in their workplace.

According to some respondents, it was helpful for the training of care staff and the further implementation of the Veder Method, if the care staff had already experienced the use of person-centred communication methods such as reminiscence, Validation[®] and emotion-oriented care (*Skills*). Several respondents indicated that staff shortages and financial pressure in the nursing and care sector negatively impacted the transfer of the method and the implementation process (*Strategy*):

... the care is subject to huge cutbacks, so really good staff members leave because the quality becomes unacceptable. You then have to deal with less professional personnel, making it even more difficult to apply new methods like this one. [RESP4, nurse assistant, NH20, INT]

The interviewees from the care home groups and Theater Veder mentioned that a lack of open communication about required time and commitment before starting the project led to both organizations having different mutual expectations, which impeded the implementation (*Systems*).

Preparation phase

A stimulating factor during the preparation phase was that all Theater Veder trainers were strongly motivated certified teachers or trainers with a background in both health care and theatre:

if I had to describe the Theater Veder company culture it is simply incredible commitment, hard work, and motivation. [RESP7, trainer, INT]

Care staff was positive about joining a living room theatre activity offered by actors (Step 1 of implementation: Observing, see the 'Methods' section) because it demonstrated how the Veder Method should be applied (*Strategy*). The respondents also reported some disadvantages regarding the living room activities offered by actors: it caused some nursing assistants or activity therapists to think that similar professional acting performances were expected from them, which initially made them reserved and insecure:

Theater Veder gave a performance here. Then they say: this is what you will be doing. That caused a bit of panic, like 'o dear'. [RESP11, activity therapist, NH3, INT]

Others indicated that they initially experienced a barrier to using theatrical elements in their work. One of them formulated this as follows:

at first I did not really see myself taking centre stage . . . but now you are a completely different person so to speak, when you are sort of hiding in your role you can respond differently. So I am glad after all that I joined. [RESP1, activity therapist, NH1, FG]

Like others, this caregiver was glad that she decided to join the training program, despite her initial doubts (*Staff*).

Execution phase

Enthusiasm of the care staff was a success factor for implementation. During the focus groups, care staff expressed their enthusiasm with words such as 'wonderful', 'great', 'fantastic', 'it gives me energy' and 'a lot of fun' (*Staff*). The care staff indicated that seeing the positive effect the method had on the residents stimulated them to continue with the implementation:

Because you can really see that the residents enjoy it. Where you would normally get no response, you now see a smile or . . . well, a response, or the person will spontaneously start to sing along, yes! [RESP1, activity therapist, NH1, focus group]

However, many staff members experienced a need for more training and on-the-job coaching. As a group activity, the Veder Method appeared to fit better with the knowledge, skills and the tasks of activity therapists than with those of nursing assistants (*Skills*). The nurse managers indicated that stimulating the staff to apply the method freely ensured that the care staff applied the method in a way that was compatible with their individual skills:

It may be, for example, that somebody who is not a great actor, who does not like to take centre stage, that this person sings a song from their own region or reads a poem or simply serves coffee. [RESP3, nurse manager, NH17, interview]

The interviewed nursing assistants also thought that many elements of the Veder Method could easily be integrated in the daily contacts in 24-hour care.

Support from all levels of the organization was needed to provide necessary preconditions, such as preparation time for organizing each living room theatre activity (*Style and Structure*). At the location where the two nurse managers were interviewed, the living room theatre activities were scheduled (long ahead of time) twice a week, which was thought to be an ideal and practicable frequency for the care staff:

Just stop and do something else for a change twice a week. Stop the everyday activity and meet each other in a different way through the Veder Method. [RESP2, nurse manager, NH17, interview]

Shared values/ethical objections: the care home group director indicated that after the introduction of the Veder Method several people were afraid that the method would be patronizing or disrespectful to people with dementia. In the focus group one caregiver said that some residents, mostly in the early stages of dementia, did indeed find the living room theatre performances childish:

Yes, because they are in the early stages of forgetfulness. They respond quite differently, often with an attitude of: don't be so childish. [RESP32, activity therapist, NH21, FG]

Yet, according to the same caregiver, even at that stage of dementia *elements* from the Veder Method, such as sayings, singing and acting could be used in the communication. Care staff also indicated that some clients felt unsafe. These feelings emerged especially when care staff was not in the room because they were preparing for the theatre activity. But during the living room activity some people with dementia also felt confused because their living room was being transformed into a theatre setting or because a familiar nurse suddenly plays a role and is therefore 'someone else' at that moment:

'Is it Anna? It is not Anna?' They would be totally distracted, you know. [RESP34, activity therapist, NH20, FG]

According to one respondent, an important precondition is that a familiar nurse who is not playing a role should attend the living room theatre activity to make clients feel safe and secure at all times.

Continuation phase

Continuation of the application of the living room theatre activity was facilitated by actively taking measures to ensure that practical preconditions were met, for example communicating clearly that a living room theatre performance was planned, what was expected from the other nursing staff members and the involvement of volunteers (*Structure*). The focus group participants viewed these practical preconditions as necessary for the continuation

of the living room theatre activity, but not always easy to realize. Several trained activity therapists mentioned that it is difficult to involve nursing staff in the living room theatre activity because nursing staff are trained to focus primarily on the physical aspects of caring, less on the psychological and emotional aspects (*Staff*):

Because care is more than just the physical, it is also about the mental aspects. But we weren't really taught that. [RESP4, nurse assistant, NH20, INT]

Also important for the continuation phase was nurse managers providing sufficient time to care staff to prepare and execute living room theatre activities and to attend the refresher days (*Style*). This lack of management support was the main reason to stop using the Veder Method:

It was so frustrating that this wonderful method just refused not take root! Just fizzled out in our organization. Management did not think it was important enough to spend money on it. [RESP34, activity therapist, NH20, FG]

It was thought that it would be helpful if the Veder Method was included in the organization's policy, for example by establishing a fixed frequency for the living room theatre activity or by organizing a number of theatre weeks annually (*Structure*). Another facilitator for implementation was the development of a digital database with ideas for central themes for living room theatre activities. Care staff of different nursing homes exchanged poems, songs and scripts related to these themes via e-mail or shared digital folders on the computer:

If somebody does something about 'summer' or 'a marriage' or something - a theme - then another person can check it out 'hey, could I use that?' [RESP8, staff communication and culture, NH3, INT]

The digital exchange provided care staff with new ideas for their living room theatre activities and saved preparation time.

Discussion

This exploratory study aimed to evaluate the process of implementing living room theatre activities in psychogeriatric wards according to the Veder Method, which means that living room theatre activities are offered by the care staff.

Stakeholders were interviewed and focus groups were organized with people involved in the implementation, i.e. activity therapists, nursing staff, nurse managers and volunteers. To structure the evaluation and to identify facilitators and barriers to implementation in different phases of the process, we developed a model we called the IPE Framework. We found that the most crucial factor for successful implementation of the Veder Method was the support of management (a factor in the category *style* in our model). Most other factors were found in the categories *structure* (i.e. providing favourable preconditions;

organizing living room theatre activities according to a fixed schedule), *strategy* (i.e. presence of an implementation plan; lack of time and money), *systems* (i.e. communication about the Veder Method in the nursing home and to relevant stakeholders), *staff* (enthusiasm; cooperation among colleagues; work pressure) and *skills* ((in)sufficient training and on-the-job coaching).

Results compared with the literature

Our study results confirm the findings of Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou (2004), which showed that the demonstrable advantage and visible benefits of an innovation facilitate its adoption (Greenhalgh et al., 2004). Similar to our findings, various other studies showed that staff being enthusiastic about the innovation is an important facilitator for implementation (Berkhout, Boumans, Mur, & Nijhuis, 2009; Meiland et al., 2005; van der Kooij, 2003). Facilitating factors such as the presence of an implementation plan, support from the management and the presence of a core group of enthusiastic people were also mentioned in a study into the implementation of 'Snoezelen[®]' (van Weert et al., 2004). Earlier studies have shown the importance of the visibility of the innovation in the organization, not implementing other major innovations at the same time, and the presence of stable key persons during the entire implementation process (Berkhout et al., 2009). Key persons were, for example, strongly motivated care staff members and managers who allowed time and money for the implementation. Other impeding factors we found in our study, such as the lack of repeated education and training, as well as staff turnover and work pressure, also appeared to be important barriers in the implementation studies of Berkhout et al. (2009) and van der Kooij et al. (2012). To safeguard the continuity and visibility of the method, it has proved important to take staff turnover into consideration; new staff must be trained when trained staff leaves the organization in order to guarantee sustainability of the Veder Method. Besides, the organization requires a manager who guarantees that staff are given time to prepare and execute the living room theatre activities frequently (preferably weekly).

The need to structurally embed the method in the organization and to involve all disciplines appeared to be essential for the sustainability of the Veder Method. Although physical care is still frequently seen as the main task of the nursing assistants, while social workers and activity therapists are responsible for meaningful activities and the emotional well-being of the residents, several other implementation studies pointed out the importance of involving the entire nursing home staff in the implementation of interventions that promote emotional well-being of the residents (Hutson & Hewner, 2001; van der Kooij et al., 2012). Another important precondition that emerged from our study was that a familiar nurse who does not play a role should attend the living room theatre activity to prevent people with dementia feeling unsafe. Compared to earlier studies on implementation of innovations in dementia care and the themes in the IPE

Framework, new factors in our study were first the digital exchange of ideas and experiences between care staff of different nursing homes as a facilitating factor for implementation. Also new were the ethical objections regarding the use of living room theatre activities for people in early-stage dementia and the importance of taking measures so that people will not feel insecure. Until now, very few studies have mentioned ethical issues with regard to psychosocial interventions for people with dementia. Another interesting outcome of our study was that many respondents stated that in addition to application in a group activity, the Veder Method is also very suitable for the one-to-one communication in 24-hour care. We therefore recommend further research into the feasibility and effectiveness of the Veder Method in 24-hour care.

Strengths and weaknesses of our study

A few strengths and weaknesses of this study need consideration. First of all, the theoretical framework developed for this study (IPE Framework) is a strength, since it provides a clear framework for the structured investigation of facilitating and impeding factors of the implementation of the Veder Method on psychogeriatric nursing home wards. By including the model of Meiland et al. (2004) in the IPE Framework, it was possible to identify facilitators and barriers in the different phases of implementation, and by including the 7s-model of Peters and Waterman (2004) the IPE Framework facilitators and barriers could be classified into 'hard' organizational aspects (structure, strategy and systems) and 'soft' organizational aspects (staff, skills, style and shared values). Although we found adding the 7s-model to the original model of Meiland et al. (2004) useful to contextualize the qualitative findings, a drawback of the IPE Framework is its complexity resulting from the integration of two theoretical models in one.

A few other methodological considerations must be mentioned. Selection bias may have occurred because four of the five focus groups were conducted during 'refresher days', whereas only one focus group was organized with people who were trained in the method but no longer applied it at the time of the study. This means that care staff who were enthusiastic about the Veder Method were probably overrepresented in our study. However, only slightly more factors impeding the implementation (i.e. lack of support from the management to set practical preconditions) were mentioned in the focus group of people who no longer visited the refresher days. The general content of the discussion in this group was similar to the other focus groups. One participant was more explicit about the negative effects of the Veder Method on clients when practical preconditions were not met.

Another limitation is that the implementation activities of the Theater Veder Foundation focused mainly on staff training. It was the responsibility of the nursing home group itself to make sure that the Veder Method was implemented in the daily routine to ensure sustainability. Some nursing homes had not yet implemented measures to safeguard sustainability of the Veder Method. As a result, facilitators and barriers for the continuation

phase were mainly based on preliminary experiences and judgements of the interviewed stakeholders and focus group participants about how the method could be sustained in the organization.

Clinical and implementation implications

The Veder Method is an appealing example with positive effects on the mood and social behaviour of people with dementia (van Dijk et al., 2012). Similar benefits and possibilities of using theatre-based communication methods for people with dementia are also underlined in other studies in which theatrical stimuli are effectively used (e.g. Caulfield, 2011, Lepp, Ringsberg, Holm, & Sellersjo, 2003; Low et al., 2013; van der Vleuten, Visser, & Meeuwesen, 2012; see also <http://www.laddertothemoon.co.uk>). Effectiveness of these communication methods depends largely on how well they are implemented in routine practice (Low et al., 2013, Vernooij-Dassen & Moniz-Cook, 2014). Nevertheless, to date little research has been conducted on the implementation of person-centred communication methods in psychogeriatric care. By using the IPE Framework, we build on existing knowledge on how to effectively implement person-centred communication methods in psychogeriatric care or other settings. Facilitators and barriers to implementation of the Veder Method provided in this study will help nursing homes determine an effective strategy for the successful implementation of the Veder Method. Moreover, this study contributes to the development of knowledge in the area of the implementation of care innovations in institutional care settings, more specifically psychogeriatric nursing home wards.

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