Chapter 4

Implementation of the Veder Contact Method in daily nursing home care for people with dementia: a process analysis according to the RE-AIM framework

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Abstract

Aims and objectives
To perform a process analysis of the implementation of the Veder Contact Method for gaining insight into factors that influence successful implementation.

Background
Research showed that the original Veder method, which is a ‘living-room theatre performance’ provided by actors, positively influenced mood and quality of life of people with dementia. Training caregivers to execute such ‘performances’ and accomplish the same effects as actors proved difficult. However, key elements of the method were considered suitable for application in daily care, resulting in the development of a modified version of the method, named the Veder Contact Method. The Veder Contact Method combines elements from existing psychosocial interventions, e.g. reminiscence, validation, and neuro-linguistic-programming with theatrical, poetic and musical communication, and applies this into daily care.

Design
For this process analysis a multiple case study design was used with the nursing home ward (n = 6) as the unit of analysis.

Methods
Eight focus groups with caregivers (n = 42) and twelve interviews with stakeholders were held. Using the Reach, Effectiveness, Adoption, Implementation, Maintenance framework, a thematic analysis was conducted.

Results
The reach of the intervention (43 – 86%) and aspects of implementation-effectiveness (e.g. increased experienced reciprocity in contact with residents) facilitated implementation. For adoption and implementation, both facilitators (e.g. development of competences, feasibility of the Veder Contact Method without requiring extra time investment) and barriers (e.g. insufficient support of management, resistance of caregivers against the Veder Contact Method, organisational problems) were identified. Little effort was put into maintenance: only one nursing home developed a long-term implementation strategy.

Conclusions
The Veder Contact Method can be applied in daily care without additional time investments. Although adopted by many caregivers, some were reluctant using the Veder Contact Method. Organisational factors (e.g. staffing and management changes, budget cuts) impeded long-term implementation.

Relevance to clinical practice
The findings from this study can be used for the development of successful implementation strategies for the Veder Contact Method and other person-centred care methods.
What does this paper contribute to the wider global clinical community?
• This process analysis shows that the Veder Contact Method (VCM), which is a new person-centred care method, is feasible in daily dementia care. VCM is easy to apply and takes no extra time.
• VCM improved the contact between caregivers and people with dementia.
• By using the RE-AIM framework this paper provides a structured overview of facilitators and barriers regarding different aspects of implementation of VCM in nursing homes. This knowledge can be helpful for other nursing homes when preparing the implementation of VCM or other person-centred care methods.
Introduction
As the interaction in nursing homes between formal caregivers and people with dementia impacts the quality of life of people with dementia (Brooker & Latham, 2015; Kitwood, 1997; Vasse et al., 2010), many person-centred care methods have been developed and their effectiveness have been researched in recent decades e.g., emotion-oriented care (Finnema et al., 2005), validation therapy, multisensory stimulation, personalised music, personalised exercise and reminiscence (Olazarán et al., 2010; Testad et al., 2014). Presently, researchers and innovators are increasingly aware of the importance of adequate implementation of person-centred care methods (Lawrence et al., 2012; Vernooij-Dassen & Moniz-Cook, 2014). In a systematic review, Boersma et al. (2015) concluded that while implementing these type of interventions more attention should be given to the adoption of the intervention and to sustainable implementation in health care settings. We therefore conducted a process analysis during the implementation of a new intervention in daily nursing home care practice, i.e. the Veder Contact Method, with the aim to contribute to the knowledge on facilitators and barriers that come along with the implementation of new person-centred interventions. Conducting such a process analyses provides insight in the way an intervention is implemented in the natural context, including the factors affecting the implementation process (Gaglio et al., 2014; Leontjevas et al., 2012).

Background
Worldwide, the number of people with dementia increases rapidly, from 47.5 million today to 75.6 million in 2030 and almost tripled by 2050 to 135.5 million (World Health Organisation, 2015). In the Netherlands 260.000 people are diagnosed with dementia and 82.000 receive or have an indication for institutionalised care (Nationaal Kompas, 2014). In a more advanced stage of the illness behavioural problems, such as depression, agitation, anxiety, apathy and aggressive behaviour, often occur with people with dementia (Bakker et al., 2011; Zuidema et al., 2007). Together with decreased cognitive and sensory abilities, many caregivers experience difficulties to communicate with people with dementia. At the same time, caregivers can do much to improve the behaviour, mood and, eventually, the quality of life in people with dementia (Vasse et al., 2010), for instance by using person-centred care interventions with specific attention for personal preferences, needs and lifestyle of the people with dementia (Kitwood, 1997; Brooker & Latham, 2015). Person-centred care interventions are aimed at fulfilling the (unmet) needs of people with dementia living in nursing homes. The most common unmet needs related to their quality of life reported by people with dementia are lack of pleasant daytime activities, company, adequate support when feeling psychologically distressed, preservation of self-esteem, e.g. being accepted for who you are, feeling attached, being understood and having social contact with family and professional caregivers (Dröes et al., 2006; Hancock et al., 2006). The rationale behind person-centred care is that this type of care facilitates the interaction and communication between people with dementia and their formal caregivers, which is assumed to have a positive impact on functioning and quality of life of people with dementia, living in nursing homes (Levy-Storms, 2008; Vasse et al., 2010). In the past decades numerous psychosocial
and person-centred interventions, such as movement activation, reminiscence, music therapy, pet therapy and ‘multi-sensory stimulation’ (Dröes et al., 2010; Olazarán et al., 2010; Van Weert et al., 2004) were developed and implemented, aimed to provide personalised support and activities to the person with dementia and to optimise their quality of life (Finnema et al., 2005; Van Mierlo et al., 2010; Testad et al., 2014). Recently, a new person-centred care method, the Veder Contact Method (from now on called VCM) was developed in the Netherlands by Foundation Theatre Veder (www.theaterveder.nl/nl/english). VCM combines core components from existing psychosocial and person-centred methods in dementia care, such as reminiscence, validation, integrated emotion-oriented care and neuro-linguistic programming, with the use of elements like theatrical, musical and poetic communication (Boersma et al., 2017). VCM is developed in response to research on the original Veder method, which has been developed as a ‘living-room theatre performance’, an interactive theatre play for people with dementia living in nursing homes performed by professional actors or trained caregivers. Both VCM and the original Veder method as ‘living-room theatre performance’ provide tools to improve communication in order to achieve reciprocity in contact and to promote feelings of well-being, identity and self-esteem for people with dementia (Van Dijk et al., 2012). The VCM-tools, procedural steps and key-elements of VCM, as well as communication strategies, are described in Table 3.

Van Dijk et al. (2012) showed in their study (n = 143) that the Veder method as a ‘living-room theatre performance’ by professional actors had a significant positive effect on the quality of life, mood and behaviour of people with dementia living in nursing homes, compared to a regular reminiscence group activity. People with dementia who participated in the ‘living-room theatre performance’ felt less ‘socially isolated’ (p = 0.04; d = -0.54), felt ‘more at home’ (p = 0.04; d = -0.41), were happier (p = 0.04; d = -0.43), recalled more memories (p = 0.01; d = 0.54), were more alert (p = 0.03; p = 0.46), and listened better to voices and other sounds (p = 0.01; d = -0.70) compared to people in the regular reminiscence group. For trained caregivers, however, it proved difficult to perform the theatre play with the same quality and intensity as the professional actors. In contrast with the performance by actors, no significant positive effects on people with dementia were found when the caregivers conducted the living-room theatre performance (Van Dijk et al., 2012). Apart from the fact that caregivers found it difficult to develop and perform a whole theatre play, Van Haeften-Van Dijk et al. (2015) also reported various implementation issues which might have contributed to this lack of effects, such as high work pressure, limited management support, simultaneous running of other (care) innovation projects, and lack of funding. At the same time, caregivers and managers indicated that elements of the Veder method as ‘living-room theatre performance’ seemed to be very suitable for application in daily 24-hour care (Van Haeften-Van Dijk et al., 2015). Following these observations, Foundation Theatre Veder developed VCM with an additional methodology and training program for caregivers in long-term care facilities on how to use VCM in daily dementia care (Boersma et al., 2017). Both the Veder method as ‘living-room theatre performance’ and VCM for daily care were developed by the director of Foundation Veder. Being an actor as well as an experienced nurse in providing care to people with dementia she recognised how theatre
could be integrated in the care of people with dementia. VCM seeks to improve the contact between the caregiver and the person with dementia within the time available during daily care events such as washing, eating, having tea/coffee, living-room activities or going to bed. Compared to the Veder method as 'living-room theatre performance', VCM has several advantages for caregivers: they can use the method continuously in their daily contact moments without setting up a more difficult and time consuming theatre performance. Despite these advantages, adequate implementation of VCM is still required to achieve the desired outcomes in terms of communication skills of professionals and quality of life of people with dementia. Although caregivers do not need the skills of professional actors to set up a theatre performance they do need essential training and motivation to learn how to use theatrical, poetic and musical communication.

Caregivers need time to integrate the method in their daily caring tasks, and managers need to support caregivers, enabling them to perform the intervention effectively (Boersma et al., 2015; Van Haeften-Van Dijk et al., 2015) Several studies showed that implementing psychosocial interventions in daily dementia care is a road with often difficult hurdles to take (Boersma et al., 2015; Eggenberger et al., 2013; Lawrence et al., 2012). Suboptimal implementation often results in a lack or even complete absence of positive outcomes in effect studies (Olazarán et al., 2010; Testad et al., 2014; Vernooij-Dassen et al., 2010). Hulscher et al. (2005) and Vernooij-Dassen & Moniz-Cook (2014) refer to this as type III error, the so-called implementation error. To prevent this implementation error, it is crucial to understand whether the implementation was carried out according to plan and achieved the desired outcomes. Only then correct conclusions can be drawn about effects of staff training and implementation (Van Haeften-Van Dijk et al., 2015). Executing a process analysis helps to gain insight into how the intervention is implemented in its natural context (Gaglio et al., 2014; Leontjevas et al., 2012). We conducted a structured process analysis to provide insight into the process of implementation, including factors that facilitated or impeded the implementation of VCM in daily care. This process analysis is part of a larger study ‘The implementation of VCM in daily nursing home care for people with dementia: an evaluation based on the RE-AIM framework’. In this larger study, in addition to the process analysis reported in the present article, the focus is also on the communication skills of caregivers who were trained in VCM, and on the perceived quality of life and behaviour of clients who were exposed to VCM (Boersma et al., 2017). The main research questions of this process analysis were:

1. How does the implementation of VCM in daily nursing home care take place?
2. What factors or conditions facilitate or impede successful implementation?

RE-AIM framework: the theoretical framework for analysis of the implementation process

To analyse the implementation of VCM and to find factors that facilitated or hindered the implementation process, we used the RE-AIM framework. The five constructs of the RE-AIM framework, Reach, Effectiveness, Adoption, Implementation, and Maintenance (Glasgow et al., 1999), that are considered important for effective and sustainable implementation,
formed the basis for the data collection and analysis in the present study. The RE-AIM framework enables a systematic description of all aspects of an implementation process and the relevant facilitating and hindering factors (Glasgow et al., 1999), e.g.: Are all caregivers reached? Do they perceive any impact on residents when applying VCM? Do they adopt the method in their daily caring tasks? Is VCM being implemented correctly, and do the nursing homes invest in assuring the continuation of the implementation? The RE-AIM framework has proven to be suitable to clearly specify the various aspects that play a role in the implementation of psychosocial interventions in nursing homes (Boersma et al., 2015). Table 1 explains the original definitions of the constructs of the RE-AIM framework as well as the slightly modified operationalisations as used in this process analysis. To avoid confusion regarding the dimension ‘Effectiveness’ (suggesting objective effectiveness of the intervention after the implementation process) we call this dimension Implementation-effectiveness. Implementation-effectiveness is defined as ‘the perceived impact of VCM on the wellbeing and quality of life of people with dementia as experienced by caregivers during the implementation process’.

<table>
<thead>
<tr>
<th>RE-AIM framework: original definition by Gaglio et al. (2014)</th>
<th>Definition in present study</th>
<th>Results: related (sub)themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reach</strong> is the absolute number, proportion and representativeness of individuals who are willing to participate in a given intervention or program</td>
<td><strong>Reach</strong> is the proportion of caregivers in the selected nursing homes that participated in the training and follow-up meetings during the study</td>
<td>No related themes, reach is measured as a percentage</td>
</tr>
</tbody>
</table>
| **Effectiveness** is the impact of an intervention on outcomes, including potential negative effects, quality of life, and economic outcomes | **Implementation-effectiveness** is the perceived impact of VCM on the wellbeing and quality of life of people with dementia as experienced by caregivers during the implementation process | - Residents having fun when applying VCM  
  - Person-centredness: recognition of the person behind the resident with dementia |
| **Adoption** is the absolute number, proportion, and representativeness of settings and the individuals within those settings who deliver the program and who are willing to initiate a program. Use of qualitative data to understand setting level adoption and staff participation | **Adoption** is the willingness of caregivers of the nursing homes to initiate VCM and deliver the program, including use of qualitative data to understand adoption on the organisation level and staff participation | - Caregiver competence: development of awareness  
  - Caregiver competence: development in contact with the residents (e.g. reciprocity in contact with residents)  
  - Caregivers competence: development in contact with colleagues |
**Implementation** is the fidelity to program protocol and adaptations made to intervention during study. Costs of intervention in time and money. Consistency of the implementation across staff, time, setting and subgroups - focus is on process -.

**Maintenance** is the extent to which a program becomes institutionalised or part of the routine of organisational practices and policies. If and how the program was adapted long term.

**Implementation** is the fidelity to VCM protocol and adaptations made to intervention during study. Costs of intervention in time and money. Consistency of implementation across staff, time, setting and subgroups - focus is on process -.

**Maintenance** is the extent to which VCM becomes institutionalised or part of the routine of organisational practices and policies. If and how VCM was adapted long term.

- Application of VCM in daily care.
- Time to apply VCM:
  - Enough time to apply VCM during daily care
  - Setting priorities
  - Saving time by doing other work in the presence of residents
- Public relations
- Costs
- Vision and strategy
- Strategies for continuation
- Ensuring long-term implementation
- Long-term support of current employees and transfer to new employees

Table 1. Relation between the procedural steps, key elements and communication strategies of the Veder Contact Method (VCM) in daily care

**Methods**

**Design**

By using this multiple case study design and qualitative research methods, we aimed to explore and understand the complex process of implementation of VCM on six wards (i.e. the six cases) through detailed in-depth data collection from two sources of information: focus group interviews with professional caregivers (from now: ‘caregivers’) and individual interviews with managers, both working in these nursing home care settings (Creswell, 2013). With this strategy of data triangulation, we aimed to gain insight into the implementation process of these six cases. The detailed, in-depth focus groups and interviews were based on topics derived from the five constructs of the RE-AIM framework. We also used this multiple case study to gain a greater confidence in the conclusions drawn from the study (Johnson et al., 2007). We spoke with caregivers and managers from the six wards separately. Firstly, because caregivers and managers might have different expectations and interests regarding the implementation (Reid & Reid, 2005) and we considered it important that participants felt free to express their ideas, regardless being in conflict with their managers’ ideas or not (Kitzinger, 1995; Krueger & Casey, 2009). Secondly, because we were interested in the opinions of the caregivers about the applicability of VCM on the ward, and in the opinions of the managers about the implementation barriers and facilitators on a more organisational level, thus separate interviews were more suitable (Reid & Reid, 2005). In the focus groups and interviews, all implementation aspects were extensively discussed. Also procedural issues were addressed in the interviews with managers and trainers of Foundation Theatre Veder, and to a lesser extent in the focus group interviews with the caregivers.
Ethical issues
This study was approved by the Medical Ethical Committee and the Scientific Committee of the EMGO Institute for Health and Care Research of the VU University medical center in Amsterdam. Prior to participation in the study the participants of the focus groups gave written informed consent to participate in the study. Prior to the interviews, all stakeholders gave oral informed consent. During the study no adverse effects occurred.

Sample and setting
Our sample consisted of six psychogeriatric wards of four nursing homes where VCM was implemented (Nursing home 1: Ward 1a & b, Ward 2a & b; Nursing home 2: Ward 3; Nursing home 3, Ward 4; Nursing home 4: Ward 5a & b, Ward 6a & b). Each ward was considered a separate case within our multiple case study. Foundation Theatre Veder recruited the first four nursing homes that were willing to implement VCM and to participate in the study, located in different parts of the Netherlands. These nursing homes had all previously used the Veder method as ‘living-room theatre performance’. The management of the participating nursing home wards signed a contract with Foundation Theatre Veder giving permission for implementing VCM on their ward and for participation in this study. By signing this contract, the managers also agreed to create the required conditions for the team to participate in the implementation of VCM. The characteristics of the participating wards are described in Table 2. Both caregivers and managers were involved in the study (See procedure and data collection).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Nursing Home 1</th>
<th>Nursing Home 2</th>
<th>Nursing Home 3</th>
<th>Nursing Home 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents</td>
<td>23+23</td>
<td>23+23</td>
<td>16</td>
<td>6+6+6</td>
</tr>
<tr>
<td>Staff-resident ratio during the day</td>
<td>1:4</td>
<td>1:4</td>
<td>1:5</td>
<td>1:4</td>
</tr>
<tr>
<td>Staff-resident ratio in the evening</td>
<td>1:6</td>
<td>1:6</td>
<td>1:8</td>
<td>1:6</td>
</tr>
<tr>
<td>Type of care-organisation</td>
<td>Large closed wards</td>
<td>Large open ward</td>
<td>Small-scale open living-rooms</td>
<td>Small-scale closed living rooms</td>
</tr>
<tr>
<td>Caregivers familiar with VM as ‘living-room theatre performance’</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes, some</td>
</tr>
</tbody>
</table>

Table 2. Characteristics of the participating experimental wards
Implementation of VCM in daily care

With VCM the caregivers learn to use the key elements, theatrical, poetic and musical communication, in daily care to stimulate a focused interaction and reciprocity in the contact with the person with dementia. In contrast with the Veder method as ‘living-room theatre performance’, VCM is set up to apply during daily caring tasks. VCM is not a group activity that costs a lot of time to prepare and execute, besides caregivers do not need to have a ‘talent for acting’. The relation between the procedural steps, the key elements and the communication strategies of VCM are described in Table 3.

<table>
<thead>
<tr>
<th>Procedural steps of VCM</th>
<th>Key elements of VCM</th>
<th>Examples of the VCM communication strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greeting by one-on-one contact</td>
<td>Theatrical communication</td>
<td>presentation/acte de présence, timing and intonation/tone</td>
</tr>
<tr>
<td>Appealing to long-term memory</td>
<td>Poetic communication</td>
<td>rhythm, associating, intonation/sound</td>
</tr>
<tr>
<td>Communication about the present time</td>
<td>Musical communication</td>
<td>recognizable songs from the past, humming, deliberate use of music</td>
</tr>
<tr>
<td>Saying goodbye</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3. The Veder Contact Method in daily care: relation between the procedural steps, key elements and communication strategies

The theatrical stimuli are applied to the (often apathetic) people with dementia, sometimes literally to wake them up, and tempt them into interaction. The consecutive procedural steps of VCM are (1) greeting by one-on-one contact, (2) appealing to long-term memory, (3) communication about the present time (connection to short-term memory), and (4) saying goodbye (Boersma et al., 2017). Foundation Theatre Veder contributed to the implementation of VCM in daily nursing home care by means of a nine-month training and coaching program (Fig. 1). Implementation barriers known from previous research (Boersma et al., 2015; Lawrence et al., 2012; Meiland et al., 2005; Van Haeften-Van Dijk et al., 2015) were anticipated. For example, VCM was adapted for application in daily care and tried out in one nursing home before the start of the implementation study; the involvement of the nursing home manager was explicitly discussed before the start of the implementation; and the transfer of VCM to the caregivers was carried out by means of an intensive and multifaceted training and coaching program. The team of caregivers of the six nursing home wards, including their managers, participated in this training and coaching program (Boersma et al., 2017). The training started with a team meeting to inform the caregivers about the method. After that, experienced observers conducted an observation according to the Dementia care mapping method (DCM), which highlights what is going well in the interaction with residents and at what points the caregivers can improve contact and better meet the wishes and needs of the residents (Brooker, 2005; Van de Ven...
et al., 2012). Subsequently, in the ‘feedback meeting’ the observations were ‘mirrored’ to and discussed by the team. Next, trainers of Foundation Theatre Veder offered the team three training sessions and two follow-up sessions. During these sessions the caregivers learned to initiate communication with the residents by means of theatrical, poetic and musical communication. Three ‘coaching on the job’ sessions took place on the wards during daily caring tasks, as the trainers observed and coached the caregivers. The training program ended with an evaluation of the training and coaching program. Finally, consultation took place with the manager of the ward to discuss how they could maintain the implementation of VCM. The implementation of VCM was closely monitored by Foundation Theatre Veder, allowing adjustments during the implementation. The implementation of VCM took place between January 2013 - October 2014. The standard training and coaching program took nine months per ward. However, because of holidays and planning problems on three wards, the planning of the first and second follow-up session had to be adjusted. This caused a variation in the training and coaching period from nine to twelve months.
Methods and procedure
Baseline information was gathered by a questionnaire before the start of the focus groups on caregivers’ age, gender, nationality, education, current position, current job experience and number of hours employed.

Reach
To assess the reach of the intervention, Foundation Theatre Veder registered participation of the caregivers in the training and coaching program. The reach was determined by calculating the percentage of caregivers participating in the five training and coaching sessions related to the total number of caregivers working on the ward (excluding temporary caregivers and newly appointed caregivers during implementation). A caregiver could be a nurse, a nursing assistant, an activity therapist, a nursing home host, a volunteer, or could perform a combination of functions, with or without the execution of coordinating activities.

Furthermore, data collection took place via focus groups with caregivers of all six wards who followed the training and attended follow-up meetings of VCM and semi-structured interviews with stakeholders who were involved in the implementation of the intervention on the nursing home wards, and with the trainers and director of VCM. The focus groups were conducted first as important outcomes for successful implementation could be included in the in-depth discussion with the stakeholders.

Focus groups
Small focus groups were composed with three to eight participants per group to allow for increased contribution of each participant (Kitzinger, 1995; Reid & Reid, 2005). The team managers of the wards asked the caregivers to participate in the focus groups, based on purposive sampling. Selection criteria were (1) participation in the training program, and (2) a variety of professions and expertise. The focus groups were held with the trained caregivers to investigate the applicability and implementation of VCM in their daily caring tasks on the nursing home wards. The first author and researcher (PB, BSc, nurse and lecturer, 4 year research experience, female) acted as moderator during the focus group interviews, four female research assistants, all without ties to Foundation Theatre Veder, acted as observers (SeY, MD, LW, LB). A predetermined ‘topic list’ based on the five constructs of the RE-AIM framework and supplemented with specific topics from the theoretical framework of Meiland et al. (2004) was developed. This theoretical framework distinguishes three phases in the implementation process: the preparation phase, the execution phase and the continuation phase, at the micro, meso and macro level and was used in another process analysis (Van Haeften-Van Dijk et al., 2015). Based on the topic list an interview schedule was composed with questions for the focus group and individual interviews. Questions for the focus groups included, for example: ‘Can you give an impression of your experiences with VCM?’, ‘Can you give an impression how VCM is implemented?’, ‘Were you facilitated sufficiently to implement VCM?’ or ‘Can you indicate what factors stimulated or hindered you to use VCM in daily care? Probing questions such as ‘Can you tell me more about that?’ or ‘What influence did your theatrical, poetic or musical communication have on the resident?’
These questions ensured clear responses from the participants and elicited detailed information during the focus groups.

**Interviews**

All managers who were involved in the implementation strategy were invited to participate in the study. We approached stakeholders by e-mail or phone describing the goal of the research and general topics that would be addressed during the interview. The interviews with stakeholders were conducted by the first author (PB). All interviews were conducted face-to-face and anonymity was guaranteed. The predetermined topic list used for the focus groups, was also used for the interviews. Questions for the stakeholders were for example: ‘How did you facilitate the implementation of VCM?’, ‘In what way was the introduction of VCM executed on your ward?’, or ‘What facilitated or hindered the implementation of VCM?’. Questions for the stakeholders from Foundation Theatre Veder were, for example: ‘What was the situation at the wards at the start of the implementation?’, ‘How did the managers of the nursing homes facilitate the implementation of VCM on their wards?’ or ‘Was VCM executed as intended?’ All interviews and focus groups were audiotaped and subsequently transcribed verbatim.

**Analysis**

Descriptive statistics were obtained on the characteristics of the participating caregivers in the focus groups. The registered participation in the training and coaching program was monitored and percentages of attendance were computed. The verbatim transcripts of the focus groups and interviews were analysed by using both deductive and inductive methods of data analysis. First, the data were coded based on a predetermined analysis scheme derived from the five constructs of the RE-AIM framework (Table 1). Next, following an inductive method, three new codes were created based on data that could not be coded appropriately with the analysis scheme created beforehand (1. involving residents/informal carers in taking the decision of implementation of VCM on the ward; 2. participation of caregivers in the training; 3. including VCM in mission/vision of the organisation). To ensure reliability of the results, and to transform the predetermined analysis scheme into an objective coding system, two researchers (PB and JvW) independently coded the first two focus groups and the first two interviews. After this was done, the objective coding system was developed and coding of the rest of the focus groups and interviews was carried out by one researcher. All codes and text fragments were entered in the qualitative software program NVivo (qualitative data analysis software; QSR International Pty Ltd. Version 10, 2012). To provide a detailed description of each case (i.e. ward), firstly a within-case analysis was carried out: text fragments from each case were organised per theme using the predetermined analysis scheme (Braun & Clarke, 2006). After analysing all cases separately, a cross-case analysis was conducted with inclusion of all cases, by analysing all text fragments related to the predetermined themes derived from the five constructs of the RE-AIM framework (Creswell, 2013). The results were summarised in matrices, categorising themes concerning the implementation process of VCM, as well as the facilitating and
impeding factors with respect to this implementation process on the micro (primary care process) and meso (organisational) level. The results were discussed in the research group (PB, JvW, RMD, BvM) thus achieving consensus on the main outcomes of the analyses. In the ‘Results’ section, quotations that reflect the responses given by interviewees are presented to illustrate the findings. The quotations are coded based on the respondents’ number (Resp) and function.

Results
Eight focus groups were held, with 42 trained caregivers from six nursing home wards. Table 4 describes the characteristics of the participants per focus group. Of the 42 participants, 90.5% ($n = 38$) attended the starting team meeting; 78.6% ($n = 33$) attended the feedback session of the DCM observations and joined at least one of the coaching-on-the-job sessions. A majority

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>FG1</th>
<th>FG2</th>
<th>FG3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Age, mean (SD)</td>
<td>43 (9.22)</td>
<td>47 (10.40)</td>
<td>46 (7.86)</td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>4 (100)</td>
<td>2 (66.7)</td>
<td>4 (100)</td>
</tr>
<tr>
<td>Function, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Nursing assistant</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Nurse and coordinator</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist and nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing home hostess</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Volunteer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Netherlands, n (%)</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Surinam/Antilles, n (%)</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other Western, n (%)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non-Western, n (%)</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No nursing education, n (%)</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Low nursing education, n (%)</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Middle-high nursing/</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Occupational education, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work in psychogeriatric care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short (&lt;1 year), n (%)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Middle (1–5 year), n (%)</td>
<td>3</td>
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<td></td>
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<tr>
<td>Long (&gt;5 year), n (%)</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 4. Characteristics of the participants of the eight focus groups ($n = 42$)
FG1 = Focus group1, FG2 = Focus group2 etc.
of the 42 participants, 73.8% (n = 31) attended four or five training- and follow-up sessions and 23.8% (n = 10) attended three training and follow-up sessions. The focus groups took place in the nursing homes and lasted 52 - 96 minutes (mean duration 73 minutes).

Eleven semi-structured interviews with stakeholders of the nursing homes were held: team managers of the participating wards (n = 6), location managers (n = 3), portfolio holder (n = 1) and advisor of the Board of Directors (n = 1), in this paper all referred to as ‘manager’. They had insight into facilitating and impeding factors of the implementation of VCM during the different implementation stages: the preparation phase, the execution phase and/or the phase of continuation. The other interviewed stakeholders were the art director of Foundation Theatre Veder (n = 1, female) and trainers of VCM (n = 3, two females), who were interviewed together. None of the stakeholders refused. The interviews took place at the nursing homes and lasted 37-98 minutes (mean duration 60 minutes).

<table>
<thead>
<tr>
<th>FG4</th>
<th>FG5</th>
<th>FG6</th>
<th>FG7</th>
<th>FG8</th>
<th>Total value</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td>42</td>
</tr>
<tr>
<td>50 (6.06)</td>
<td>47 (7.46)</td>
<td>48 (13.29)</td>
<td>52 (9.61)</td>
<td>44 (12.65)</td>
<td>47 (10.02)</td>
</tr>
<tr>
<td>5 (100)</td>
<td>4 (100)</td>
<td>7 (100)</td>
<td>6 (85.7)</td>
<td>8 (100)</td>
<td>40 (94.2)</td>
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<tr>
<td>1</td>
<td>2</td>
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<td>3</td>
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<td>15 (35.7)</td>
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<tr>
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<td>1</td>
<td>2</td>
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<td>1</td>
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</tr>
<tr>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>6 (14.3)</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5 (11.9)</td>
</tr>
<tr>
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<td>1</td>
<td>1 (2.4)</td>
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<td>1</td>
<td>1</td>
<td>5 (11.9)</td>
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<td>1 (2.4)</td>
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<td>7</td>
<td>27 (64.3)</td>
</tr>
<tr>
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<td>6 (14.3)</td>
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<tr>
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<td>1</td>
<td>0</td>
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<tr>
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<td>3</td>
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<td>6</td>
<td>8</td>
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<td></td>
<td>2</td>
<td>13 (31.0)</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>3</td>
<td>27 (64.3)</td>
</tr>
</tbody>
</table>
RE-AIM framework
For each construct of the RE-AIM framework the themes related to the implementation of VCM are described. An overview of the related (sub)themes to the five constructs of the RE-AIM is given in Table 1. Subsequently, the notable barriers and facilitators per theme are described (refer to Table 5 for an overview of the barriers and facilitators).

<table>
<thead>
<tr>
<th>RE-AIM construct</th>
<th>Facilitators</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach</td>
<td>• Mandatory participation in training and follow-up meetings</td>
<td>• Irregular working hours</td>
</tr>
<tr>
<td></td>
<td>• A stricter procedure to implement training and coaching program</td>
<td>• Doing the training outside regular working hours</td>
</tr>
<tr>
<td></td>
<td>• Doing the training together as a team</td>
<td>• Inadequate management supervision</td>
</tr>
<tr>
<td></td>
<td>• Offering training at two moments to ensure everyone can participate</td>
<td></td>
</tr>
<tr>
<td>Implementation-effectiveness</td>
<td>• Small-scale care setting and rural environment</td>
<td>• Lack of background information on the residents</td>
</tr>
<tr>
<td></td>
<td>• Positive and cheerful reactions of the residents (reciprocity in contact)</td>
<td>• Caregivers not allowed to wear their own clothes (negative effect on homelike atmosphere)</td>
</tr>
<tr>
<td></td>
<td>• Collaborating with enthusiastic (Veder) colleagues</td>
<td>• Apathetic or silent residents (people with moderate to severe dementia)</td>
</tr>
<tr>
<td></td>
<td>• Easy applicability of the VCM in daily care</td>
<td>• Limited communication skills of caregivers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inability to focus on VCM program because of other ward issues</td>
</tr>
<tr>
<td>Adoption</td>
<td>• DCM, DVD and positive approach of the training and coaching program</td>
<td>• Resistance against the use of key elements of VCM</td>
</tr>
<tr>
<td></td>
<td>• Cheerfulness and contact with colleagues in training and follow-up meetings</td>
<td>• Too much attention during training for organisational problems on the ward with family/insufficient support from management/ absenteeism</td>
</tr>
<tr>
<td></td>
<td>• VCM application creates connectedness and reciprocity with colleagues and residents</td>
<td>• Different cultures in a team made collaboration difficult</td>
</tr>
<tr>
<td></td>
<td>• Giving more specific assignments during the training</td>
<td>• Insufficient learning culture on the ward</td>
</tr>
<tr>
<td></td>
<td>• Practical approach of the training and coaching program</td>
<td>• Change of trainers</td>
</tr>
<tr>
<td></td>
<td>• Offering the training and follow-up in a way that you show more of yourself as a colleague, but also as a person</td>
<td>• Some parts of the training were perceived as childish</td>
</tr>
<tr>
<td></td>
<td>• Doing the training together as a team</td>
<td>• Apathetic behaviour of caregivers during training influenced behaviour of trainers, who had to stay alert not to exhibit apathetic behaviour themselves</td>
</tr>
<tr>
<td></td>
<td>• Involvement of and stimulation by the management</td>
<td>• Some aspects of VCM do not suit a caregiver’s personality (e.g. theatricality)</td>
</tr>
<tr>
<td></td>
<td>• VCM is a method that caregivers can also use in collaboration with other disciplines</td>
<td></td>
</tr>
<tr>
<td>RE-AIM construct</td>
<td>Facilitators</td>
<td>Barriers</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Implementation</td>
<td>• VCM is an invitation to equality and recognition (being present). VCM finds openings in people with dementia, making happy encounters possible&lt;br&gt;• VCM takes no extra time and is easy to integrate into daily care duties.&lt;br&gt;• VCM is easily applicable, not complicated, no special investments are needed; it's all about personality and enthusiasm&lt;br&gt;• VCM is an important addition to the Veder method as ‘living-room performance’&lt;br&gt;• Not having office space forces caregivers to increase their presence in the living room with residents&lt;br&gt;• VCM fits well with the development of self-managing teams and integration of tasks of various staff members of a team (e.g. activity therapists, nurses, hostesses)&lt;br&gt;• Facilitation by the organisation&lt;br&gt;• Support within the team&lt;br&gt;• Long duration of the training and coaching program&lt;br&gt;• Inexpensive training and coaching</td>
<td>• Unclear who is responsible for the registration of residents’ background information&lt;br&gt;• Life-story books are poorly made by relatives&lt;br&gt;• In case caregivers have an office: a tendency to retire in their own office to do administrative tasks instead of being in the living room with the residents&lt;br&gt;• Tendency to focus on to-do task lists&lt;br&gt;• Hastiness of the caregivers due to high workload&lt;br&gt;• Integration of tasks of activity therapists and nurses results in less time to do activities with residents&lt;br&gt;• Development towards self-managing teams (which resulted in a higher workload) while implementing VCM&lt;br&gt;• Low education level of caregivers&lt;br&gt;• Poor mastery of the Dutch language&lt;br&gt;• High absenteeism of caregivers</td>
</tr>
<tr>
<td>Maintenance</td>
<td>• VCM and Veder method as ‘living-room performance’ is likely for an organisation to distinct themselves&lt;br&gt;• Senior management sees the necessity of sustainable implementation and takes steps for continuation&lt;br&gt;• Applicability of VCM as a shared method when conducting discussions/ (multidisciplinary) consultations/performance appraisal / team-development discussions&lt;br&gt;• Transfer of VCM on a resident level to new caregivers is easy&lt;br&gt;• Availability of a regular education and training budget</td>
<td>• Lack of vision and decisiveness on long-term implementation of senior management&lt;br&gt;• Lack of a long-term implementation plan&lt;br&gt;• Focus on implementation is diverted by inspection visits, budget cuts, management and staffing changes&lt;br&gt;• Insufficient directive guidance to identify an informal leader and/or project leader&lt;br&gt;• Lack of a training budget</td>
</tr>
</tbody>
</table>

Table 5. Facilitators and barriers during the implementation of VCM
RE-AIM construct I: Reach

The reach in this study is the proportion of caregivers in nursing homes that participated in the training and follow-up meetings during the study. Table 6 shows that on five wards the reach was moderate to good (67%–86%). On these wards the caregivers reported that the training contributed to team building, which facilitated the reach. The team of W2a & b did not experience this. The main barrier was the change of management, which resulted in the caregivers receiving less encouragement to participate in the training.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Nursing home</th>
<th>Number of caregivers* working on the ward at T0 (n)</th>
<th>Reach at T1 (%)</th>
<th>Number of caregivers** who attended one training or follow-up meeting (n)</th>
<th>Number of caregivers** who attended all (five) training and follow-up meetings (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>W1a &amp; b</td>
<td>1</td>
<td>42</td>
<td>67</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>W2a &amp; b</td>
<td>1</td>
<td>41</td>
<td>43</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>W3</td>
<td>2</td>
<td>20</td>
<td>74</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>W4</td>
<td>3</td>
<td>22</td>
<td>79</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>W5a &amp; b</td>
<td>4</td>
<td>21</td>
<td>69</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>W6a &amp; 6</td>
<td>4</td>
<td>19</td>
<td>86</td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 6. Reach of the training of VCM

* Caregivers are: nurses, nursing assistants, activity therapists, combined function of activity therapist and nursing assistant, combined function of nurse and coordinator of the ward, nursing home hostesses, volunteers. Excluded are temporary caregivers and caregivers starting new on the ward during implementation.

** Number of caregivers from total caregivers at T0.

RE-AIM construct II: Implementation-effectiveness

**Implementation-effectiveness** is the perceived impact of VCM on the wellbeing and quality of life of people with dementia as experienced by caregivers when applying VCM. Two themes were identified in relation to the implementation-effectiveness.

1. Residents having fun during application of VCM

During the execution phase, on most participating wards (W1a & b – partly -, W3, W4, W5b, W6a & b) caregivers managed to apply theatrical, musical and/or poetic elements in their communication with residents during daily care moments, and reported that they experienced fun when applying VCM, but also that the care was easier to give, e.g. it evoked less resistance from the residents. VCM could be applied as a small activity together with
the residents (e.g. quote Resp29, nurse), but it could also be a change of music in the living room. For example, the residents appreciated different styles of music being played resulting in positive responses; on another ward a nurse (Resp31) recited old poems in the residents’ own dialect, producing smiles on residents’ faces:

“Since the training I use the internet to play music they know, not just the radio. And Elvis Presley, they love it and you hear them say: ‘Oh, this is Elvis Presley’ and then they start to dance." (Resp19, hostess)

On five wards (W1a & b, W3, W4, W5a & b, W6a & b) the caregivers indicated that residents experienced pleasure when caregivers applied VCM:

“When I work with M, we call G. G then comes to play the piano and we take the residents into the hall. I put on a boa, a robe and I walk past all residents, sing with them and give them a friendly pat on the head. We really have 20 minutes of fun with the residents.” (Resp29, nurse)

Caregivers on W2a & b and a few caregivers on W1a & b and W5a indicated that they found it difficult to apply VCM. They felt that theatrical, musical and/or poetic communication did not fit their personality. However, trainers of Foundation Theatre Veder believe that every caregiver feels comfortable with a form of theatrical, musical or poetic communication. Although the trainers tried to anticipate this by using ‘experiential learning’ techniques, such as demonstrating theatrical characters (e.g. the trainer showed up as a postman, a form of ‘acte de présence’, while the caregivers assumed the role of residents), it was not enough for some caregivers to overcome their resistance and gain more self-confidence in applying VCM (Trainers Foundation Theatre Veder).

2. Person-centredness: recognition of the person behind the resident with dementia.
On four wards (W3, W4, W5b, W6a & b) the caregivers experienced that the implementation of VCM led to a greater recognition of the person behind the resident with dementia and to more reciprocity in the contact with the people with dementia:

“We placed a suitcase with goodies of yesteryear on the table. A resident who used to be a bicycle repairman took some bike stuff from the suitcase. That was a fun and special experience because without any prompting he began to tell stories about his life as a bicycle repairman.” (Resp29, nurse)

On W2a & b the caregivers reported they found it difficult to empathise with the world of the residents. One barrier was having little information about the background and personal interests of the residents. This problem also existed on W1a & b and W5a, but caregivers on these wards discovered that by applying VCM they gained valuable insights on the interests of the person with dementia.
Summarising the *implementation-effectiveness*, in the perception of caregivers and managers applying VCM has a positive influence on the wellbeing of the people with dementia, although using the theatrical elements of VCM does not suit all caregivers.

**RE-AIM construct III: Adoption**

*Adoption* can be defined as the willingness of caregivers and trainers to initiate VCM and deliver the program. Willingness of caregivers to change their behaviour, e.g. having more attention for the quality of life of people with dementia, strengthened their competences. Three themes related to adoption emerged from the focus groups and interviews.

   The training started with a film about the Veder method as ‘living-room theatre performance’, which demonstrated how to make contact in a touching way. Trainers reported that this was often the moment when resistance against VCM decreased. On four wards (W1a & b, W3, W4, W6a & b), observation of the residents using the DCM-method and the feedback about these observations to the team, led to insight into how they acted and communicated with the residents during the care process. Some caregivers were really shocked by the observations as they realised how they neglected some residents. The positive focus of the training facilitated caregivers to gain more self-confidence and it stimulated their motivation to learn. For the caregivers from W2a & b and some from W5a the training did not result in increased awareness. During the training, these caregivers focused too much on problems like the absence of management and colleagues, and issues with family of the residents.

2. Caregiver competence development in contact with the residents.
   Caregivers of all six wards (W3, W4, W5b, W6a & b and some caregivers of W1a & b, W2a & b and W5a) reported that because of their willingness to engage in self-reflection and by using VCM they experienced more connectedness/reciprocity in contact with the residents. This resulted in having a more genuine attention for individual residents:

   Resp20, nurse: “Previously, you were seen as a nurse. There was a certain distance. But now, if you talk to a resident one-on-one, our contact is more equal.”
   Int: “So you are looked upon differently by the residents.”
   Resp20, nurse: “Yes.”
   Int: “And do you also feel that you look differently at the residents?”
   Resp20, nurse: “Yes, I feel closer. They share small secrets with you. And in return I’ll tell a small secret (e.g. the date of my birthday) and say: Don’t tell anyone?”

   A number of caregivers of W1a & b, W2a & b and W5a indicated they found it difficult to communicate with apathetic residents and/or residents who display repetitive behaviour. It was an eye-opener for them that it is possible to validate the experiences and emotions of these patients with severe dementia.
3. Caregiver competence development in contact with colleagues.
On all six wards the participating caregivers in the focus groups reported that the training was built up gradually in terms of showing oneself as a colleague but also as a person who dares to be vulnerable in the presence of colleagues. On wards W1a & b (partly), W3, W4, W5a & b and W6a & b this resulted in more mutual trust, which stimulated the collaboration between the various disciplines in the team: caregivers, therapists, hostesses and volunteers. A manager (Resp48) reported that the nursing assistants in particular, those who are not well educated on dementia, experienced the VCM training and coaching program as very helpful for providing better person-centred care in their new role as nursing assistant. Also, it was easier for the caregivers, therapists, hostesses and volunteers to appeal to each other: ‘Is this how we learned to do it during VCM trainings?’ (Resp20, nurse). Caregivers on W2a & b and some on W1a & b, however, did not experience this improvement in cooperation, since working together with different cultures and difficulties with the Dutch language remained dominant barriers for effective collaboration within the team. VCM provided the caregivers on all other wards with a method that facilitated discussing the behaviour of residents with other staff members, and as result being accepted as a full partner in multidisciplinary meetings:

“In the multidisciplinary consultation (with physician, dietician, psychologist and/or music therapist) the caregivers now feel more confident to propose alternative ways of dealing with difficult behaviour. If these new ways work, the general recommendation regarding dealing with difficult behaviour is adapted.” (Resp17, nurse and coordinator)

Summarising the adoption, both caregivers and managers reported that VCM created awareness and helped caregivers to develop their professional competences, in terms of both caring tasks and cooperating with colleagues.

**RE-AIM construct IV: Implementation**
Within the context of the present study implementation is defined as fidelity to the VCM protocol, adaptations made to the intervention during the study, costs of the intervention, and consistency of implementation across staff, time, setting and subgroups. Trainers reported that all teams received the same amount of training and follow-up sessions, team meetings and coaching-on-the-job. No adaptations were made to the intervention. Four themes related to implementation have been identified.

1. Application of VCM in daily care.
Caregivers and managers from five wards (W3, W4, W5a & b, W6a & b, some of W1a & b) stated that VCM is easy to apply in daily practice:

“The method is easy to apply, all caregivers have talents to apply the method, and nothing extra is needed.” (Resp48, manager)
However, both caregivers and managers of W2a & b indicated that caregivers did not apply VCM often. Caregivers of W1a & b and W2a & b believed that VCM was used best during caring tasks in the bedroom and the bathroom. Commotion in the living rooms made it difficult for them to apply VCM adequately to individual residents. On wards W2a & b and W5a caregivers reported that the implementation of VCM was hindered by organisational problems, such as absence of caregivers and managers, high workload and collaboration problems with colleagues. It is striking that while a change of management and high absenteeism occurred on both wards W5a and W5b, these were not mentioned by W5b as an impeding factor to successful implementation. According to the manager, team W5a and W5b had different team cultures: “They differ notably in self-management and collaboration.”

2. Time to apply VCM.
‘Time’ is a major issue in nursing home care. The influence of VCM on the factor ‘time’ is described in three sub-themes.

a) Enough time to apply VCM during daily care.
Most caregivers of five wards (W1a & b, W3, W4, W5b, W6a & b) reported that the execution of VCM took no extra time. The method was easily integrated in their daily professional activities:

“Once you cross the ward’s doorstep you start applying VCM.” (Resp51, manager)

Some caregivers from these same wards, as well as caregivers from W5a and W2a & b, indicated that performing caring tasks is often done in a rush, meaning that applying VCM properly was difficult. A manager attributed this to differences in handling stress:

“Caregivers differ in how well they tolerate high work pressure; this probably depends on their personalities.” (Resp50, manager)

b) Setting priorities.
Caregivers on five wards (W1a & b, W3, W4, W5B, W6a & b) indicated that the training forced them to face the facts: performing care calmly, making one-on-one contact and having patience meant that both the caregivers and the residents are more at ease and comfortable. And this saved time during the rest of the day! Still, some caregivers of wards W2a & b, W4 and W5a & b indicated that they found it really hard to let go of the ‘traditional’ time schedule (e.g. all residents must be washed, dressed and finish breakfast before 10:30 a.m.):

“Caregivers still make an issue of time while time is not an issue, the nursing home is a 24-hour business.” (Resp43, manager)

c) Saving time by doing other work in the presence of residents (e.g. in the living room).
Caregivers of W3, W5a & b and W6a & b conducted the administrative work in the presence
of residents. For them, paying attention to the residents while doing other chores resulted in extra time for the social and emotional wellbeing of the residents. On these wards caregivers had no office space, for them it was ‘normal’ to do administrative work in the presence of the residents. Although caregivers of W4 are also used to do administrative work in the small-scale living room, they did not experience they had extra time for the residents due to the integration of the tasks of nurses and activity therapists. Nurses were obliged to do activities with residents, and activity therapists had to perform simple caring tasks. Most caregivers of W1a & b and W2a & b found it hard to carry out administrative work in the presence of residents, they preferred to write their reports in the office. Due to this mindset and a high workload, caregivers of these two wards were unable to, for example, take time to clean up together with the residents and to combine this with having a personal talk with the residents.

3. Public Relations (PR).
The caregivers of W4 and the managers of W5a & b and W6a & b realised that by using VCM the nursing home could distinguish itself from other nursing homes in the region. This opportunity of positive PR stimulated the higher management of these wards to invest in long-term implementation of VCM. On W4, however, the manager retired during the implementation period, and at the same time the team of W4 had to become self-managing. These changes resulted in the senior management being less involved with the implementation and consequently W4 did not benefit from this opportunity of positive PR of VCM.

The participating wards received grants for participation in this VCM-project. As a result all managers considered the implementation trajectory inexpensive, which made it attractive to implement VCM.

Summarising the implementation, on W2a & b both caregivers and managers reported that the implementation of VCM had not been successful. On wards where both reported it was successful, caregivers and managers found VCM easy to apply during daily caring tasks, as it took no extra time. Caregivers and managers reported VCM is useful for PR, but only two of the six wards managed to actually use it for this purpose.

**RE-AIM construct V: Maintenance**

*Maintenance* describes the extent to which VCM was institutionalised and became part of the organisations routine practice and policy. From the focus groups and interviews four themes related to long-term sustainability.

1. Vision and strategy.
VCM fitted the person-centred care vision of all participating nursing homes. However, after implementation the management of W1a & b, W2a & b, W3 and W4 did not promote the
method on other wards/locations of their nursing homes. Barriers were a lack of vision and decisiveness regarding the long-term implementation and decreasing attention for the implementation of VCM because of other activities demanding their attention, such as inspection visits, budget cuts, and management and staffing changes.

2. Strategies for continuation.
Only the board of directors of W5a & b and W6a & b acknowledged the importance of continuing the implementation of VCM and undertook long-term implementation actions:
• Anchoring VCM hierarchically within the organisation, moving beyond the pilot status.
• Involving senior management in sustainable implementation.
• Broadening the support base among all staff of the organisation.
• Including VCM in regular business processes.

3. Ensuring long-term implementation.
After the nine-month training and coaching program the senior management from W5a & b and W6a & b wrote a long-term implementation plan, focused on securing, extending and broadening the support base (spreading the ‘Veder virus’):

"The start of the implementation was 'spur of the moment', some were excited and they just went ahead, without a sound and long-term implementation plan. In hindsight the implementation should have taken place on a larger scale."
(Resp53, manager)

The board of W5a & b and W6a & b took the initiative to appoint enthusiastic personnel as portfolio holders; these employees presented themselves spontaneously. Senior management of the other nursing homes identified no project leader or portfolio holder. Caregivers of W1a & b, W3, W4, W5a & b and W6a & b reported that they wanted to remain inspired and expressed the need for ‘Veder ambassadors’ within the organisation and that they could meet internally and externally:

"To remain inspired, I would like to have a Veder method 'living-room theatre performance' on our ward a few times a year." (Resp7, nursing assistant)

Foundation Theatre Veder expressed the wish to develop a certification mark.

4. Long-term support of current employees and transfer to new employees.
Caregivers of all wards indicated that VCM is easily transferred to new employees during daily care activities. In the nursing home of W5a & b and W6a & b a follow-up training of the method was added to the regular course offerings, funded from the regular education budget of the organisation. In the nursing homes of W1a & b, W2a & b, W3 and W4 no budget was available for this purpose.
Summarising the maintenance, caregivers need more support and investment from the management to continue applying VCM in the long run. Managers of four wards failed to develop a long-term implementation plan, due to a lack of vision, budget cuts, inspection visits and management and staffing changes.

Discussion

By means of a multiple case study design, we described the implementation process of VCM on six nursing home wards for people with dementia. The RE-AIM framework enabled us to evaluate the degree to which the implementation has been successful and provided insight into the facilitators and barriers during the implementation process. Below we discuss the implementation of VCM and the main facilitators and barriers we found for each RE-AIM construct. The reach was moderate to good on five wards (67% – 86%) and poor on one ward. Foundation Theatre Veder, stressing the importance of the role of the manager in the preparation phase of the implementation process, could not prevent the latter. Several studies identified the importance of a supportive and facilitating manager during the implementation (Boersma et al., 2015; Chenoweth, 2015; Lawrence et al., 2012; Van Haeften-Van Dijk et al., 2015; Van Weert et al., 2004). The current research shows that the manager also has a major impact on the caregivers participating in the training, which is a first crucial step for a successful implementation. It is of great importance that management consistently conveys the message to staff members that the application of VCM is important basic care, and that caregivers learn to stick to using the method even in less than optimal circumstances. Remarkably, some teams simply had more difficulties dealing with organisational problems on the ward, like the absence of the manager and/or colleagues, than other teams. A hypothesis is that not the organisational problems on the ward as such are barriers to successful implementation, but how a team deals with them is of greater importance. Team culture, the system and the interconnected and interacting individuals determine whether a team is ready to adopt a new care method (Snoeren et al., 2014). Caregivers who succeeded in applying elements of VCM became better at tailoring their communication to the individual needs of the residents and the person behind the dementia, which resulted in residents enjoying themselves more, and less resistance to daily caring tasks (implementation-effectiveness). This means that VCM supported the caregivers greatly with the operationalisation of person-centred care (Brooker & Latham, 2015; Kitwood, 1997). More specifically, VCM helped caregivers to be more ‘present’ with the residents, by ‘connecting’ with the residents, ‘attuning’ to the residents and ‘being of significant meaning’ for the residents, which corresponds with the presence theory (Baart & Vosman, 2011). Lawrence et al. (2012) report that the use of a psychosocial intervention leads to ‘more meaningful relations’ between the resident and the caregiver. To effectively provide person-centred care, caregivers need information about the background and personal interests of the residents. As found in Broderick & Coffey (2013), this information was not always available, which was a barrier to successful implementation on two wards. However, in addition to developing more effective ways to retrieve this information, the application of the multi-faceted VCM training and coaching program, including careful observation of the reactions of the residents,
provides valuable insight into their personal interests and preferences. When caregivers use theatrical, poetic or musical communication in their contact with residents and are willing to reflect on themselves, they develop competences in making contact with the residents and with colleagues (adoption). In this way, the VCM training and coaching program helps caregivers to professionalise their work, which has been reported previously as a potential asset of psychosocial interventions in dementia care (Chenoweth, 2015; Eggenberger et al., 2013). Although the trainers of Foundation Theatre Veder state that every person has skills for theatrical, poetic or musical communication, not all caregivers were able to overcome their resistance to using VCM in their daily caring tasks. Some caregivers reported, in line with the studies of De Lange (2004) on integrated emotion-oriented care and Götell et al. (2009) on caregiver singing and music, that VCM does not fit their personality and they feel uncomfortable with it. In retrospect, more ‘experiential learning’ (Snoeren, 2015) in the training might be useful to increase the caregivers’ familiarity with the communication tools of VCM. On wards where compliance with VCM was higher, the training helped caregivers to reflect, correct and encourage each other. Providing feedback appears to be as important as the intervention itself, because it stimulates ‘ongoing learning’ (Eggenberger et al., 2013; Snoeren, 2015). As reported before, the long duration of the training, the follow-up sessions and coaching-on-the-job are also important ‘boosters’ to successful implementation of VCM (Boersma et al., 2015; Lawrence et al., 2012). An important barrier mentioned in previous studies on implementing psychosocial methods was ‘the time it takes’ (Boersma et al., 2015; Eggenberger et al., 2013). VCM was set up to be implemented during daily caring tasks like washing, eating or going to bed. Both caregivers and managers of five of the six wards confirm that VCM required ‘no extra time’. From a practical point of view, caregivers and managers therefore concluded that VCM is easy to implement in daily care, which corresponds with Lawrence et al. (2012), who state that integrating a person-centred method in daily caring tasks facilitates successful implementation (implementation). It must be noted however that, although a minority, some caregivers found it difficult to apply VCM when the workload is high. The high workload made it difficult to take the time and to be creative using theatrical, poetic or musical communication in the contact with the residents. In addition to ‘time’, two related themes emerged in this study. ‘Setting priorities’ is still an issue in nursing homes. Van Weert et al. (2004) also found that caregivers tend to do their work based on ‘the clock’. It is difficult for them to change the daily planning and to approach nursing home care as a 24-hour business. The third theme, ‘doing work in the presence of the residents’ appeared to save time and more importantly, working this way increased the caregivers’ attention for the social and emotional wellbeing of the residents. Gnaedinger (2003) and McAllister & Silvermann (1999) found that playing multiple and integrated roles, for example combining caring tasks with housekeeping tasks and formal activities, encouraged caregivers to respond to the social, emotional, physical and medical needs of residents. Caregivers had integrated roles on wards where the care was organised in small-scale living-rooms (see Table 2). On a micro level maintaining the implementation of VCM seems easy for caregivers, because the method is considered easy to transfer to (new) colleagues (maintenance). Although VCM fits the vision of all participating nursing homes,
so far only one of the four nursing homes has achieved sustainable implementation (continuation phase) on a meso level. Important facilitating factors like structural financing of the implementation, securing the method in regular business processes and benefitting from the positive PR that comes along with VCM have been reported earlier (Meiland et al., 2005; Van Haeften-Van Dijk et al., 2015). Contrary with the facilitating factors described by Meiland et al. (2005), this specific nursing home started implementation without a long-term (implementation) plan. This organisation ‘just started’ the implementing of VCM. Later on in the process, they performed a number of actions to maintain the implementation of VCM, such as developing and financing a long-term implementation plan and including VCM in the regular business processes. This process is consistent with Snoeren et al. (2014), who concluded that improvement of care and cultural change in nursing homes are dynamic, interactive and non-linear processes that take place at the same time. These are complex processes, making prediction and control difficult, and they require managers with a supportive and flexible attitude. ‘Just start’ and adjust during the implementation process might also be a right path to follow after all.

Strengths and limitations of the study
Several methodological issues in this process analysis need to be taken into consideration. Strengths of the study are:

• All involved stakeholders of the implementation of VCM (caregivers, managers on different levels of the organisation and trainers from the Foundation Theatre Veder) were interviewed by the same researcher, using the same protocol.
• Data analysis was structured on a predetermined analysis scheme based upon the RE-AIM framework.
• To promote the reliability of the process analysis the data of the first two focus groups and interviews were analysed by two independent researchers, with little disagreement between the two researchers.
• There was no dependency between Foundation Theatre Veder who developed and implemented VCM and the researchers.

Despite these strengths, some limitations must be mentioned.
• In this multiple case study we used a standard protocol both for the focus groups and for individual interviews, which was prepared beforehand. This resulted in some themes being only ‘briefly discussed’. During the analysis it became clear that further exploration of some issues could have resulted in better insight into the implementation process, for example why a team on one ward experienced the absence of management as an impeding factor, whereas the implementation in another team was not hindered by the absence of management.
• In this process analysis we investigated the perspectives of caregivers and managers of six nursing home wards. Although relevant, we did not ask the people with dementia or their informal caregivers about their experiences with VCM.
• There was variation in the settings involved in this study: the six wards differed in the
type of care organisation, the number of residents living on the ward and the region of the Netherlands where they were located. Because of these differences we have to be cautious to make generalisations about facilitators and barriers to implementation of VCM, as they may have been related to specific contextual factors of the different wards.

• As described earlier there was also variation in the period Foundation Veder needed to implement VCM; on three wards this took nine months, on the three other wards it took twelve months, due to planning problems. This may have influenced the implementation process and the facilitating and hindering implementation factors we found.

• The last limitation of this study is related to the qualitative methods used in this study. We have interviewed caregivers and managers of the experimental wards, who shared with us the factors they perceived as facilitating or hindering the implementation. However, observing the behaviour of the caregivers may complement the information derived from the focus groups and interviews. It is recommended that further research also use other ways of data collection, such as observations how caregivers communicate with residents in daily practice, additional to what they retrospectively say about the implementation.

Conclusions
Using the five constructs of the RE-AIM framework we gained insight into the way the implementation of VCM is executed and which facilitators and barriers were encountered on the micro and the meso level. Although Foundation Theatre Veder offered all meetings of the training and coaching program on two different days, the reach varied between the wards. Managers still have an important role in stimulating caregivers. On a micro level, caregivers on four of the six wards adopted the method and succeeded in applying VCM during their daily caring tasks like washing, eating and going to bed. In the short-term VCM was implemented fairly successfully, caregivers learned a lot and were positive about the application of VCM in their daily caring tasks. Caregivers and managers reported that VCM had a positive influence on the quality of life of the people with dementia, e.g. increased reciprocity in interaction between caregivers and residents. Maintaining the implementation of VCM in the long run, is still an issue. On a meso level, senior management from only one nursing home initiated actions to maintain VCM; they integrated VCM and the Veder method as ‘living-room theatre performance’ in their regular business and care processes. The most important facilitator of the implementation was that the method is easily applied and takes no extra time. Most important barriers to the implementation of VCM were resistance against theatrical communication, dealing with organisational and staffing problems on the ward, and no continuation with a long-term implementation plan or finances for extra training or VCM inspirational meetings.

Relevance to clinical practice
Just as Lawrence et al. (2012) describe for the United Kingdom, the care for people with dementia is also changing in the Netherlands. Less staff will have to take care of more residents and residents move to the nursing home later in the course of their disease (Van Haeften-van Dijk et al., 2015). In this ‘changing landscape’ of lower staff-to-resident ratios and more complex care needs among residents, the caregivers and managers implemented
Another radical change in the Dutch dementia care is the emergence of self-managing teams, where the function of the team managers has disappeared and the team has more responsibilities, e.g. making up their own duty roster, choosing and planning their training. The implementation of VCM has helped most teams to start a dialogue about how care is provided and what is important for people with dementia. With the development of self-managing teams, nurses become more autonomous (Kieft et al., 2014). On the other hand, not all self-managing teams are able to implement a new person-centred care method without the daily presence of a stimulating and facilitating manager. We found that the majority of the participating caregivers experienced more satisfaction and enjoyment in their contact with residents during the implementation of VCM, and that the method required no extra time investment from caregivers, which positively contributed to the integration of VCM in the daily caring tasks. Despite these encouraging findings, some barriers were experienced by caregivers when implementing VCM:

- insufficient management supervision and support;
- lack of vision and decisiveness on long-term implementation by the management of the nursing homes;
- little information available about the personal interests and background of the residents;
- high work pressure.

Moreover, some caregivers felt uncomfortable using theatrical, musical or poetic communication, some caregivers and some wards had staff with different cultural backgrounds, which made it more difficult for them work well together. Successful implementation of VCM requires that these hurdles are taken into account. However, in the follow-up of this study we will also investigate the implementation-effectiveness by means of observing the behaviour of caregivers and residents to find out whether the increased knowledge has actually led to more person-centred care. This part of the study will be published in the near future. Although there is increasing awareness of the importance of implementation studies (Gaglio et al., 2014; Leontjevas et al., 2012; Vernooij-Dassen & Moniz-Cook, 2014) and the value of a process analysis, these are still not common practice. For example, this process analysis resulted in the realisation that both innovators (e.g. Foundation Theatre Veder) and managers of nursing homes have to take more responsibility for the implementation of VCM. The RE-AIM framework helps to gain insight into the course of the implementation process. This study shows the value of conducting a systematic process analysis using this framework. It appears to be an effective approach to operationalise the different facilitating and impeding factors of implementation of VCM. Insight into these implementation factors will help caregivers and managers of international nursing homes who want to implement VCM or other person-centred methods in daily dementia care to anticipate the hurdles along the way.
References


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