ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Facilitation of a workplace learning intervention in a fluctuating context: an ethnographic, participatory research project in a nursing home in Norway

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Abstract

Background: This single-site nursing home study is part of a larger cluster-randomised controlled trial that aimed to reduce staff use of restraint. The cluster-RCT study involved 24 nursing homes, and investigated the effect of a standardised education intervention to reduce restraint in dementia care with a person-centred care approach. This article draws on empirical data from one of the nursing homes in the control group of the trial, at which the education intervention was tailored to better account for contextual circumstances.

Aim: To explore how a tailored education intervention can reduce the use of restraint in a nursing home. The study aims to investigate what local contextual circumstances influenced the process of facilitation of the intervention.

Methods: The study was theoretically informed by the Promoting Action Research Implementation in Health Services (PARiHS) framework, with practice development principles to address local learning needs and contextual issues. External facilitators tailored the education intervention in collaboration with the nursing home leader and staff. A participatory design with data collection based on principles of critical ethnography was used to evaluate the intervention.

Results: Fluctuation emerged as the core theme from the evaluation: fluctuating enthusiasm among staff, fluctuating nursing home culture and fluctuating responses by nursing home residents.

Conclusion: The study offers insights into the interplay between a tailored facilitation intervention and fluctuating contextual circumstances in a nursing home.

Implications for practice:

- A successful education intervention requires facilitators who can take into consideration and adapt to fluctuations in the context
- Facilitation skills must include the ability to value team experiences, recognise learning needs, provide feedback and participate in finding solutions in the moment
- Flexibility is important in terms of how new knowledge can be used in person-centred ways, notably in attempts to reduce the use of restraint in dementia care

Keywords: Dementia, restraint, critical ethnography, PARiHS framework, tailored education intervention, person-centred care

Introduction

The Norwegian government responded to extensive use of restraint in nursing homes by introducing a new chapter in the 2009 Patient's Rights Act (Norwegian Ministry of Health and Care Services, 2009), requiring restraint to be used only as a last resort in persons lacking the capacity to give informed consent. The act recommends that 'confidence-building alternatives' based on person-centred care be used to minimise restraint and improve care for residents living with dementia. National education programmes in terms of seminars for health professionals, information materials and legal support from regional health authorities have been implemented to support the new legislation (Testad et al., 2015). The case study presented here was part of a larger study called Modelling and Evaluating eviDence-based Continuing Education program in Dementia care (MEDCED), set up as a consequence of the new legislation and using a standardised education intervention with a person-centred care approach. This article takes empirical data from one of the nursing homes in the MEDCED control group, with the education intervention tailored to the home's particular context.

Background

Earlier research has questioned the effectiveness of standardised education initiatives in reducing the use of restraint in dementia care. There seems to be a gap between what researchers suggest is 'best practice' and the way this practice is implemented (Huizing et al., 2009; Möhler et al., 2011; Zwijsen et al., 2014; Testad et al., 2015; Mekki et al., 2017). There are theoretical assumptions that increased understanding of persons living with dementia and agitation can help staff to find person-centred, confidence-building alternatives to restraint (Mekki et al., 2017). On the other hand, less is known about the outcome of the person-centred approaches in the context of responding to people with dementia who become agitated.

Harvey and Kitson (2015) suggest standardised education interventions are not always implemented in a way that fits the local context and culture. The process of implementing and learning new knowledge to improve care is not a straightforward one, and new knowledge has little impact unless practising clinicians can implement it in line with contextual circumstances and local needs (Chisholm et al., 2018). Overall, most practice development and implementation studies indicate that a tailored education intervention suited to local circumstances is needed (Best et al., 2008; McCormack, 2009; Pentland et al., 2011; Perry et al., 2011; Dewing et al., 2013; Marchal et al., 2013; Rycroft-Malone et al., 2013; Harvey and Kitson, 2015; van der Donk and Kuijer-Siebelink, 2015). Moreover, the revision of the PARiHS framework – i-PARiHS – singles out the facilitator as the active ingredient that integrates the innovation, recipients and the context (Harvey and Kitson, 2015). In order to tailor an educational intervention it is necessary to understand staff perception of new knowledge and of their actions (Chisholm et al., 2018). Six contextual factors have been identified as having a significant bearing on the use of new knowledge: the role of nurse; multifaceted access to resources; organisational climate; multifaceted support; time for research activities; and provision of education (Meijers et al., 2006). These authors' findings suggest that contextual factors may influence the development of environments that are conductive to implementing new knowledge, and should be investigated further. Further, implementing any aspect of person-centred care with external facilitation in nursing homes is increasingly acknowledged as a complex process that must take local contextual circumstances into consideration (McCormack et al., 2010; Øye et al., 2015). When tailoring an intervention the facilitator must be able to recognise and overcome contextual barriers to improving care (Harvey and Kitson, 2015; Lo et al., 2018).

Several authors, (McCormack and Titchen, 2006; Shaw et al., 2008; Berta et al., 2010; Seers et al., 2012; Hardiman and Dewing, 2014) have argued that the facilitators' role is pivotal to ensuring the implementation of person-centred ways to improve care. Yet, the process of facilitation and how to facilitate effectively continue to be debated extensively (Harvey et al., 2002; Jansson et al., 2011; Dogherty et al., 2012; Seers et al., 2012; Dewar and Sharp, 2013; Hardiman and Dewing, 2014; van Lieshout and Cardiff, 2015). There is little generalised knowledge about how to construct facilitation

processes and the behaviours of facilitators, but we know there is an association between the contextual circumstances and the way the facilitator tailors the implementation of new knowledge (Berta et al., 2015; Lo et al., 2018); facilitators must be able to adapt to the context. Also, van Lieshout and Cardiff (2015) suggest there are principles that promote and sustain a relational reciprocity when exploring ways of tailoring an education intervention in a person-centred way. Thus, it is claimed that the facilitators' role and skillset should be flexible, but the effectiveness is variously defined and measured. However, communication and relationship building seem to be key components in the multifaceted and flexible process of facilitation, through building a participatory staff team (Dogherty et al., 2012). More than this, Schön (1987, p 22) argues that the process of facilitation requires professional artistry, while Harvey et al. (2009, p 221-222) exemplify the dialectical process of professional artistry in healthcare facilitation as a 'dance', which emerges through conversations enabled by the professional processes of attunement, interplay, synchronicity, synergy, melding, blending and balance. Titchen et al. (2013, p 109) add that facilitation of person-centred cultures within the clinical or care context is highly skilled work composed of many cycles and rhythms. Finally, a successful facilitation process has the potential to stimulate higher-order learning in organisations through experimenting with small-scale adaptations to workplace processes and work routines (Berta et al., 2015).

Thus, this paper explores the role of contextual circumstances in the relationship between external facilitators and nursing home staff and their leader during a six-month tailored education intervention to promote person-centred ways to reduce the use of restraint in a nursing home.

Research questions
- In what way can a tailored education intervention promote a person-centred approach to care?
- What kind of local contextual circumstances influence the process of facilitation?

Method
The overall mixed-methods MEDCED study, of which the single site in this study was a part, set out to evaluate the effect and implementation process of a standardised educational intervention in 24 nursing homes in Norway. The intervention was based on person-centred values (McCormack and McCance, 2010), to improve collective staff decision making in order to reduce the use of restraint and psychotropic drugs in agitated persons living with dementia (see table 1).

Table 1: The MEDCED seven-step decision making model (Mekki et al. 2017) used during the facilitation both in the wider trial and the single site from the control group studied here
Step 1 Description of the situation
Step 2 Understanding of the situation
Step 3 Recognition and acceptance of care staffs' situation and feelings towards staff-resident relations
Step 4 Reflecting on the patient situation and the care staff-resident relations
Step 5 Problem solving and choice of intervention
Step 6 Performing of the intervention
Step 7 Evaluation of the intervention

The PARiHS framework theoretically informed the intervention design, and was used to capture the complex interplay of factors that influence the implementation of an intervention (Mekki et al., 2017). PARiHS proposes that successful translation of evidence into practice is a function of the interplay between the evidence, the context in which translation is happening and the way in which implementation is facilitated (Harvey and Kitson, 2015). This intervention was implemented by two facilitators during a two-day seminar for all staff and their leaders, followed by six monthly facilitated sessions. Twelve nursing homes were randomised to achieve the intervention, and the remaining 12 in the control group were offered and accepted the opportunity to receive the intervention once the follow-up data had been gathered.

When analysing the trial data from the standardised MEDCED intervention, a significant reduction in the use of restraint in all nursing homes was identified, although this was greater in the control group (Testad et al., 2015). When these findings were combined with qualitative data, it was agreed that contextual circumstances in relation to external and internal facilitation could partly explain the success or failure of the intervention in particular nursing homes (Øye et al., 2015, 2016; Testad et al., 2015; Mekki, 2015, 2017; Jacobsen et al., 2017). After the 12 control-group homes had received the intervention at a later stage, as agreed, it was decided to try a different approach in one of these homes, in cooperation with the leader and staff, in order to explore the success or failure of an educational intervention tailored to the workplace contextual circumstances.

Setting and participants
The nursing home in this study is an average-sized facility located in a small town in western Norway, and the tailored intervention was performed from September 2013 until mid-March 2014. The home was chosen from those in the MEDCED study because it had the highest agitations scores, as measured by the Cohen-Mansfield Inventory (Testad et al., 2015). Moreover, it had also the lowest levels of registered nurses among the MEDCED sites. The average findings from this home showed that four out of eight residents were subjected to at least one restraint measure per week, which was also high compared with the other homes in the control group. All the older persons living in the facility had a diagnosis of dementia, and psychotropic drugs as well as physical and relational restraint were prescribed (Jacobsen et al., 2017). The tailored education intervention focused on reducing relational and physical restraint and was built around a seven-step decision-making model (Testad et al., 2005). This is illustrated in table 2.

Table 2: The seven steps of the six-month educational intervention			
	Educational intervention	**Research methods used during the formal intervention sessions**	**Research methods used in the workplace and in between the formal sessions**
Step 1	Establishing contact with the nursing home leaders and clarifying the premise for the practice development		
Step 2	Two-day seminar: 'Trust before restraint'	Participant observation and reflective journal: 10 participants	Participant observation, informal interviews
Steps 3, 4 and 5	Three sessions of facilitation	Participant observation and reflective journal: seven participants at the first and second sessions, four at the third	Participant observation, formal and informal interviews
Step 6	Seminar on communication skills (Marte Meo method) in addition to the facilitation, as shown in box 2	Participant observation and reflective journal: seven participants	Participant observation, formal and informal interviews
Step 7	Facilitation	Participant observation and reflective journal: eight participants	Participant observation, formal and informal interviews
Closure	A closure of the study by evaluating and discussing the process, as well as arranging a seminar to discuss outcomes related to workplace learning		

This article primarily focuses on data from two of the older people living in the facility; one of them, 'Tom', is described in box 1.

Box 1: Case study – the facilitation process

Case study: 'Tom' has been living with dementia many years. When he became increasingly restless and agitated, and he needed more help with personal care than his wife could provide, he came to live in the nursing home. The staff spoke of Tom as being agitated; they experienced biting, spitting and pinching from him when trying to help with his personal hygiene. One of the staff used to hold his hands firmly, while another changed his continence wear.

Steps 1 and 2: Contacting the nursing home and providing a seminar in theoretical and legislative issues based on person-centered initiatives aimed at reducing the use of restraint.

Step 3: Introduction of facilitators to care home staff. A welcoming atmosphere in the home greeted the facilitators. In order to avoid the use of restraint the staff members had requested to be facilitated. They were a little reticent at the beginning of the facilitation process and the nursing home leader actively tried out different methods to involve her team. Some of the staff actively shared their experiences of working and intervening with Tom, while others were uncomfortable with doing so. The facilitators asked questions and challenged everyone to contribute, but some still preferred to remain silent. Staff were given tasks to try before the next meeting regarding Tom's medical condition, and asked to pay greater attention to small details as a way to begin developing confidence-building alternatives to restraint.

Step 4: Before the facilitation meeting the facilitators received an email explaining improvements in Tom's medical treatment. The staff had engaged with family members to seek their input for the purpose of minimising the use of restraint. They found out that Tom calmed down when he had a wet towel in his lap while being washed. During our meetings we had developed a relationship with staff members and decided during the dialectical process to explore each one's experiences with caring for Tom. This process engaged all staff members and important information emerged. Despite staff trying to be person-centred, Tom was still agitated during personal hygiene situations. The staff realised that firmly holding his hands, even though it was done to avoid harm, constituted restraint. They agreed on new confidence-building initiatives, such as doing his podiatry when a family member was present and could talk to him, for example about his interest in boats.

Step 5: In the next facilitation meeting the staff expressed confusion that the initiatives helped on some days, but on others they still experienced biting, spitting and pinching. Tom's agitation challenged the staff emotionally: some dreaded going to work while others were reluctant to help Tom with his personal hygiene. During the session the facilitators recognised these emotions. One staff member showed wounds on her arms, saying she was broken-hearted, feeling sorry both for Tom and for herself in not being able to handle him. They agreed on further confidence-building initiatives – the use of time-out if Tom showed resistance and the presence of an extra staff member ready to help or 'take turns' with Tom's care. The staff also became aware of the need to learn more about communication, particularly to elicit meaning from both verbal and nonverbal communication. At the request of the leader and the staff, the facilitators decided to introduce Marte Meo communication, based on person-centered care in order to help reduce the agitation and use of restraint.

The team was stable and the staff had worked together for many years. As members of the local community, they generally had knowledge of the older persons prior to their coming to live in the nursing home. There was one registered nurse, six auxiliary nurses and two assistant nurses. Seven out of nine staff members had permanent full-time positions, and there was no turnover of staff during the six-month study period. Both the staff and the nursing home leader were eager to learn more about person-centred care approaches and confidence-building alternatives to the use of restraint.

The tailored education intervention

The education intervention was tailored to the nursing home's contextual circumstances. Initially, two external facilitators (the first and fourth authors: HD and AH), facilitated a two-day seminar followed by five one-hour facilitation sessions in the facility over the six-month period. The tailored intervention was based on the stepwise decision-making model shown in table 1 (Testad et al., 2005). The model is inspired by the ideas of Kitwood (1997), and aims to improve collective decision making about using person-centred interventions (Dewing, 2008; McCormack and McCance, 2010) as an alternative to restraint. On request from the staff and leader, a one-day seminar focusing on communication skills and the Marte Meo model was organised. The Marte Meo is a method developed by Maria Aarts (2000) initially to strengthen and develop the interaction between children and their parents. However, it has been adapted to improve communication skills in dementia care (Sørensen, 2015). Here, the method focused on what works in dialogue with older people, and how it can be made more constructive and enable staff to develop restraint-free solutions. The two facilitators offered the staff opportunities to

learn as a group and to develop deeper insights into effective communication with persons living with dementia. They also encouraged the staff to consider factors in their context and culture that could influence their use of confidence-building initiatives in place of restraint. Discussions led to solution-focused processes with a greater effort on person-centred care (See box 1, above).

Practice development and critical ethnography
This single-site study draws on key principles from practice development to address local learning needs and contextual issues. Critical ethnography principles were used for the data collection and evaluation of the tailored education intervention (Madison, 2012). This approach was chosen as it tends to be participatory in nature, not only exploring what the contextual and cultural setting looks like, but also trying to answer the question, 'what can be done about it?' through a reflexive inquiry (Cook, 2005). The critical ethnographer in this study (CØ) worked directly with and for the people who were studied by using participant observation as the main method. Critical ethnography seeks to combine critical perspectives with practical knowledge in order to promote emancipatory change alongside the persons being observed in practice (Madison, 2012). Such an approach was used in this evaluation to explore how the tailored education intervention was talked about and used in 'the care moment' by the team. Moreover, the approach shed light on unacknowledged biases that may result from unspoken values, in order to provide new avenues for reflexive inquiry and dialogue around improvement of the person-centred care initiatives to reduce the use of restraint (Foley and Valenzuela, 2005; Madison, 2012). The critical ethnographer functioned as a data collector, being a participant observer, and as a cultural broker working in close cooperation with the facilitators to transform the workplace culture to become more person-centred. She explored the dialogue and negotiation in context about person-centred interventions within the team as they attempted to find solutions that reduced the use of restraint; she observed 'moments' of movement (Dewing, 2010) in relation to how, when and under what circumstances the new approaches to care were or were not being used by this team and in this context. In addition, the ethnographer carried out formal and informal interviews addressing aspects of restraint in relation to person-centred care. The ethnographic data were recorded at the facility in a notebook and transcribed later in Norwegian, using a computer or notebook, recording what was heard or observed as faithfully as possible using standard punctuation and spelling (Silverman, 2005).

Due to the participatory nature of the implementation and the evaluation, the project team took on dual roles as implementation facilitators and co-evaluators (HD and AH). Further, the team sought to create context-specific conditions that enabled staff to transform their practice into something more person-centred (McCormack et al., 2013). To develop a culture of person-centredness the approaches to the older persons were in line with the person-centred framework: engagement; shared decision-making; having sympathetic presence; and providing holistic care (McCormack and McCance, 2017).

Evaluation and analysis
For the analysis, the data were translated from Norwegian to English. After each learning session, the participating researchers (the authors) completed structured written reflection notes adapted from the PARiHS framework (Mekki et al., 2015). These were included as data because they provided contextual background to the process of facilitation.

The research team used a three-part analysis. The first part drew on creative hermeneutic knowledge co-production as described by McCormack et al. (2010). This analysis resulted in the creation of a visual image representing shared knowledge of the overwhelmingly complex and fluctuating nature of implementation. It showed a dark and a light side, with a variation to indicate constant changing of both helpful and obstructive factors. Dialogue led to the emergence of the theme of fluctuation. The second part of the analysis was an ethnographic thematic analysis using a setting-specific coding procedure (Lofland et al., 2006), based on particular activities, conduct, perceptions, events and interactions in the nursing home. The third part was a general thematic analysis of the team's written reflections, focusing on the contextual elements and on what was observed and done by the facilitators. Then all the initial findings were presented and discussed with staff and the nursing home

leader on two occasions, to enable a deeper dialogue about the data and findings and to encourage further workplace learning. All original data collection and analysis was written up in Norwegian.

Research ethical approval and considerations
The larger MEDCED study was formally approved by the Regional Committee for Medical and Health Research Ethics in Norway and The Norwegian Social Science Data Services. All participants were anonymised and gave informed consent. Where it had been established and confirmed that a person lacked the capacity to consent, their next of kin were asked to consent on their behalf. The workplace observations were carried out in a way that prioritised and maintained the dignity and privacy of the older persons and the team. In any situation where the person was becoming increasingly agitated and/or the observer's presence seemed to be a contributing factor, the observer withdrew.

Findings
In summary, a core theme of 'fluctuation' emerged, with three subthemes:
- Fluctuating enthusiasm among staff
- A fluctuating nursing home culture
- Fluctuating responses by older persons

The concept of fluctuation relates to knowledge translation and can be understood as a dynamic and fluid process incorporating multiple sources (Ward et al., 2012). The fluctuations were found to be significant, specifically in staff members' capacity to sustain day-by-day and hour-by-hour enthusiasm in person-centred care delivery and in reciprocal relationships with the older persons. It appears that staff struggle to apply new knowledge consistently where there are fluctuations in older persons' behaviour, where their energy to maintain their connection with the older persons is not stable and when they feel the need to prioritise efficiency.

Fluctuating enthusiasm among staff
These findings indicate that the team members responded differently to the facilitation; some were eager to learn and share their experiences and others less so, while some were not comfortable speaking or sharing their thoughts in a group setting. The team members agreed during one session to use Marte Meo communication skills (Aarts, 2000) in their responses. Later, when interviewed, they were positive about the seminar that introduced these skills. One team member said in an interview:

> *'This has been fabulous. I have been to many seminars but this is the best and the most relevant related to our daily working life challenges. We have agreed on what to do, and experienced some results.'*

One day the observer saw a staff member using the Marte Meo principles to get a resident's attention. The staff member sat down next to the resident, who was looking out of the window. She tried to talk about what they saw through the window, and by doing so got the resident's attention. After some time, the resident became receptive to doing something else, and agreed to move to the dinner table without any protest. This avoided the use of any type of restraint, in contrast to staff's earlier experiences when trying to move the person for meals or other activities.

The interview data showed that, over time, team members felt more positive towards the facilitators and the facilitation, as one staff member said:

> *'We were listened to, and able to contribute with our experiences. They were also fun to listen to. There was never a dull moment.'*

After the first facilitation session, observations showed that the team voiced a positive attitude. As one member said during the daily report:

> *'The facilitation was very useful, but one hour was not enough to dwell on the experiences we have. However, it was very useful to share the different experiences we have with Tom.'*

During the daily report, team members were keen to discuss the challenge they faced with Tom biting, spitting and pinching them during personal hygiene situations:

> *'One day I can manage him just fine, but the next day he is shouting loudly that I am hurting him, I do not know what to do'* [staff member shows scratches on her arm from Tom].

The team had high expectations of the facilitation. For example, before one of the sessions, they had been guided by the facilitator to carry out some learning activities in the workplace, connected to knowing Tom and his needs better. They hoped this would lead to a solution. However, Tom's family advised the staff to be 'determined and loud' towards him, saying he would listen and be calmer. But one staff member said, 'I cannot be determined or loud' because she equated this to being less person-centred. Instead, the team decided to bring a male nurse from another unit to support Tom's personal hygiene. The male nurse was able to care for him without using restraint and without being assaulted. Although this initially seemed to be a solution, the staff were disappointed when, after a few days, Tom also began to assault their male colleague during personal care. Despite having a positive attitude towards the facilitation, their experience trying different solutions with Tom without consistently being able to meet his needs led to a reduction in enthusiasm. At this point, the team started doubting that they would be able to stop using restraint. One staff member said during a handover:

> *'I don't know if I ever actually believed that this "case" would be easy to solve, but anyway it is always useful to discuss it with other colleagues.'*

With some encouragement from the clinical leader, the team agreed to experiment with further approaches without using restraint. The staff members were facilitated to consider what worked for Tom in other situations. They had found he was calmer when he had something to hold on to, so they offered him a towel to hold while they washed him. This worked only for a few days before Tom again started to respond in ways staff found challenging. Accordingly, the staff decided to try having two members provide his personal hygiene. However, they were seen to focus on protecting themselves from spitting and biting. The staff did continue to consider and try measures they could offer that would help Tom feel safer and thus prevent him from responding with behaviour staff found challenging. For example, they agreed to spend more time and invite Tom to take part in his personal hygiene. However, their frustration of not having 'solved the case' meant their feelings continued to fluctuate . One member said in an interview:

> *'No days are alike; some days things work perfectly without having to use restraint and the next day nothing works… so you can never know what to do. You have to be sensitive to the situation at hand.'*

However, after a few months the observations indicated staff were applying what they had learned during facilitation sessions. Instead of giving up and returning to a set of routines, they realised there were no quick fixes or any one 'solution' to the behaviour. Rather, they were using different interventions in more person-centred ways depending on Tom's identified needs at any particular time. Over time, similar findings were seen with other older persons in the unit.

Fluctuating nursing home culture

Field notes identified that several institutional barriers could hinder the implementation of measures to avoid the use of restraint. The home leader, for example, noticed that some of the team forgot about their learning amid the demands of their care work:

> *'We have to be reminded all the time, these communication principles should be up on the wall every day… We should act both verbally and nonverbally in accordance with these principles… We have to remind each other in each meeting and in handovers on a daily basis, and also tell each other when we are not following these principles.'*

While the staff appeared to be aware of the Marte Meo communication principles, they seemed to experience difficulties in acting in accordance with them because of the busy nature of their work. As one staff member said:

> *'We can be tired, and sometimes even exhausted, and we forget to communicate in ways that reduce agitation.'*

The observations and interviews showed that some team members did not act according to principles of person-centred care on various occasions. This was especially evident in bath and personal hygiene situations. Staff appeared to feel caught between task-focused and person-centred care. Another member confirmed this:

> *'You know, with all the residents in the home and having all the tasks to be completed, I get tired, especially mentally tired, and I don't act in accordance with what I have learned or should do.'*

In their daily report, for example, negative talk about some of the older persons who were restless could be heard. Often it was said they were tired of trying to calm them down. In one example, a member said:

> *'Today Tom has been very restless, I tried to get him to sit down with me, but he kept on going and going. And as soon as I get him to sit down to eat, he takes a bite and gets up again… I don't know what to do to make him rest… the restless walking must be very tiring for him also.'*

The critical ethnographer also observed examples of staff taking time and demonstrating a sincere interest in older persons and connecting with them in meaningful ways. For example, an older person was looking in a magazine and bent over to a member of staff, pointing at the page in the magazine and asking: 'Is this a sender?' The team member looked at the magazine and joined in, searching for what he was looking at, being interested and asking questions. The older person was affirmed and respected, rather than corrected. The ethnographer later asked what a 'sender' is. The staff member replied, 'I don't know, but he needs to be validated or else I know that he can become confused and restless.'

Fluctuating responses by older persons

Staff experienced variations in the level of agitation and responses to their initiatives from some older persons. They reported the day-to-day care for some of the residents was unpredictable and made the planning of initiatives to reduce restraint challenging:

> *'You never know what he will be like today, you have to wait and see… No days are alike, one day everything can go just smoothly, but we have to watch out, suddenly Tom can spit or bite us.'*

The fluctuation in older persons' responses was also evident in the daily reports:

'This morning Tom smelled of urine, so I started very slowly and explained carefully what I was going to do, and I started singing just calmly as I did yesterday, when everything went well… I did what we agreed on, but what happened just as I almost managed to get him to the bathroom, he pinched me.'

Another member confirmed:

'Well, it is not easy to know what to do, when everything goes fine one day, and the next day you experience this.'

There were multiple examples showing that the staff team was more skilled at offering support and comfort to each other than at asking challenging questions and finding solutions for the older person. This was especially seen when a standardised solution did not work and when they seemed, at first, unable to find new solutions. For example, an auxiliary nurse said during a handover based on the supervision from the facilitators:

'I was so happy the other day when we came up with the idea of diversion of his [Tom's] attention by giving him a piece of clothing to be occupied with while preparing him for a bath. I tell you this did not work for very long, he started screaming again just as he heard the water running. Another auxiliary nurse said: "We have all experienced this, so don't feel bad, even though it is frustrating".'

It was observed that the facilitation input created renewed moments of enthusiasm for staff, but the sharp fluctuations in older persons' responses and conditions seemed to cause frustration. For example, the condition of one resident, 'Jane', tended to worsen after each facilitation session, making it very hard to follow up on interventions collectively agreed during the facilitation session. In one example, the team tried to follow up with a measure aimed at helping Jane be less restless by engaging with her interest in handicraft. A team member went with Jane to a handicraft store and they looked at some knitted work and planned to do some knitting together. This person-centred activity brought a lot of joy to Jane. However, her medical condition worsened just a few days after and she was no longer able to be involved in knitting.

Discussion

This study shows that the regular fluctuations in the conditions of older persons living with dementia means reducing restraint use is not a straightforward or linear process. This finding is in line with the wider MEDCED study, in which, while there was a statistically significant reduction in use of restraint in 24 nursing homes, the reduction was greater in the control group than in the intervention group (Testad et al., 2015). Previous studies (Huizing et al., 2009; Möhler et al., 2011; Zwijsen et al., 2014) and the overall MEDCED study also indicate that reducing restraint is a complex matter highly dependent on contextual factors (Øye et al., 2016). It is important to consider contextual factors and context-sensitive facilitation when using a standarised educational intervention.

The fluctuating responses by older persons influenced staff enthusiasm. The implementation of person-centred care to reduce restraint led to what the staff perceived as additional complexity in practice. The complexity was generally experienced by staff as challenging, because they lacked the skills to apply knowledge that was personalised to each resident and to the specific condition of that person on a particular day, as opposed to an intervention being applied to the person in all situations each day. Furthermore, there was no guarantee for how long a new restraint-reducing initiative would be effective. Mostly, staff wanted clear and somewhat fixed solutions, which they often perceived as long-term solutions. Staff also had unrealistic expectations about some of the care interventions. For example, while the staff team was more aware of alternative solutions to draw on, their enthusiasm

for these quickly faded if they did not work consistently. This study's data show that while the staff set out to learn more about the older persons and to improve or innovate their care, they could easily lose enthusiasm and confidence in finding 'new' person-centred care interventions. Finding the energy and enthusiasm continuously to re-assess and come up with alternative solutions to reduce restraint was experienced as tiring. This may also point to a need for more knowledge about how people live with dementia and the daily fluctuations of the condition. The team, therefore, valued workplace learning and the presence of an external facilitator who could help to enthuse and suggest a range of possible confidence-building alternatives. Among the contextual factors in implementation of new knowledge identified by Meijers et al. (2006) are different types of support reminders and provision of education. This is in line with previous findings that practitioners are almost three times more likely to adopt evidence-based guidelines when they receive workplace facilitation (Baskerville et al., 2012).

Staff enthusiasm and spirit to improve or innovate their care was also influenced by the fluctuation in the nursing home culture. They had few opportunities to discuss and try out restraint-reducing initiatives due to the busy nature of their work and sudden interruptions from residents. Most often, it was observed that staff were interrupted by other residents or colleagues, which could disrupt person-centred interventions and result in a more task-oriented approach. Staff got tired and sometimes forgot to communicate in the ways that they had learned as part of their education intervention. The observations showed that various team members were, in some situations, unable to act according to principle of person-centred care, for example to communicate in ways that reduced agitation. Staff stated that they became mentally tired and this often affected their ability to implement their learning. Furthermore, they expressed the need to be 'reminded' of how to be more person-centred in their interaction with older persons, particularly in the context of bathing and personal hygiene situations. The staff found it challenging to act consistently in accordance with person-centred principles across different care situations. Therefore, their care performance became occasionally more task-focused than person-centred.

The team found the facilitation was useful. It targeted their needs – for example, to ensure more constructive dialogues that enable them to work together as a team to find restraint-free solutions in day-to-day care despite disruptions. This study's findings support previous research suggesting facilitation is an essential component of implementing evidence (Rycroft-Malone et al., 2002; Harvey and Kitson, 2015) and developing person-centred cultures (McCormack et al., 2013). Also, facilitation can enable engagement (Dewing and McCormack, 2015), build relationships and maintain momentum (McCance et al., 2013). The findings are in line with those elsewhere that aspects of person-centred care is a complex process and external facilitators must take local contextual circumstances into consideration (McCormack et al., 2010; Øye et al., 2015), and suggest novel research designs should be developed accordingly. Therefore, a research design should be sensitive to context, making tailoring of interventions a recommended method (Grol et al., 2005; Best et al., 2008; Pentland et al., 2011). However, as this study shows, tailoring to local circumstances is challenging due to the nature of fluctuations within a workplace culture. Further, this study indicates that variations such as fluctuations in staff enthusiasm, nursing home culture and responses by residents, are important and dynamic factors to consider when tailoring an education intervention. This echoes findings from Stetler et al., (2014) among others, who argue the need to plan for a complex set of interacting factors when implementing person-centred care.

During the six-month facilitation period the facilitators were able to build a relationship based on trust, enabling the staff to share their experiences and frustrations. The findings also reveal that the staff enjoyed and were energised by the facilitated education sessions, so this type of intervention may offer a way to sustain staff enthusiasm and revitalise their efforts to meet the older persons' needs in a person-centred way. Overall, the enabling factors most valued by the staff team during the workplace learning and facilitation process were acknowledgment of their experiences and recognition of how they felt as a consequence of the responses and reactions from some of the older persons. Moreover,

they valued the facilitators' feedback on their efforts to find new solutions in the moment. The main inhibiting factor seems to have been the interplay between the three sets of fluctuations, leading to an overall contextual complexity in day-to-day care practices, although it is not possible to say whether any one of the three had a stronger influence than the others. These findings may add weight to arguments from Stetler et al., (2014) and van der Zijpp et al., (2016), that facilitation is essential for successful implementation.

The process of facilitation is not an 'act of magic' introduced from the outside, but rather a dialogical process (Schön, 1987), based on reflexive considerations in the moment when surrounded by fluctuating circumstances. The process can be likened to a form of professional artistry like a 'dance' that encompasses attunement, synchronicity and interplay within the complexity of the setting (Harvey et al., 2009). Bolton (2010) claims that a facilitator does not so much lead as create a culture where others lead themselves. Hence, the facilitator stays in uncertainty alongside the participants, achieving active dynamic engagement. In this study, the facilitators validated the participants' success and failure using person-centred principles. Facilitation, then, has the potential to stimulate and embrace person-centred values in practice, such as sustaining small-scale adaptations to organisational processes and work routines despite circumstantial 'ups and downs' (Seers et al., 2012; Berta et al., 2015).

This study also confirms that successful implementation of person-centred care to reduce restraint can result from an interplay between how the nursing staff perceive the utility of the intervention in their specific context, their ability to respond to fluctuations in the residents' agitation levels and in cultural elements, and the external facilitation input. This is in line with suggestions in the original PARiHS framework (Kitson et al., 2008), as well as its revision, to address more explicitly the inter-relationship and dynamism between the framework's elements and sub-elements (Rycroft-Malone et al., 2013). This is also proposed by Harvey and Kitson (2015) in the revised i-PARiHS framework, who argue that facilitation is 'an active ingredient that integrates the innovation, the recipients and the context' (p 217). This study advances the claim that the facilitators had to use a variety of skills and actions similar to those i-PARiHS describes as traits of expert facilitators, and illuminates the need for a deeper adaptation and sensitivity to local fluctuating elements. This could be achieved by way of including such factors as workbased collective learning needs, something not clearly integrated in PARiHS.

Limitations and implications
Tailoring a workplace education intervention is a complex task. This study gives a limited picture of the complexity of facilitation and workplace learning in general, since it took place in a single nursing home. However, the intent is not to generalise but to understand the facilitation process in relation to contextual circumstances when facilitating a tailored workplace learning intervention. Further, the study was not as participatory as it could have been, as staff in the home contributed less to some aspects of the study than others. The study could have been enhanced by recruiting more nursing homes from among the MEDCED control sites. It would be useful for researchers to include in future research, a variance of fluctuating elements that staff struggle with when aiming to sustain best practice. There is a need for more research regarding the facilitators' role and the reflexive considerations in the moment when surrounded by fluctuating circumstances.

Conclusion
Three key points are highlighted here. First, to be successful in reducing the use of restraint with nursing home residents living with dementia, education interventions should be tailored by facilitators in close collaboration with staff and clinical leaders. This study has shown that to move towards a more person-centred practice that minimises the use of restraint, the process of facilitation should be flexible enough to respond to local fluctuating circumstances and learning needs. Second, to promote a person-centred culture, the study offers insights into the concepts of fluctuation in a contextualised tailored education intervention. The facilitation was influenced by fluctuating responses by older persons, fluctuating enthusiasm by staff and fluctuating nursing home culture. The facilitation process enabled staff to sustain their energies and beliefs in the value of the intervention despite some experiences of unsuccessful efforts in practice. Successful facilitation was found to require a

skillset that includes valuing team experiences and acknowledging staff feelings arising from residents' responses to them. This study also highlights the need for facilitators to prepare staff to be more effective in finding solutions in specific moments when they are surrounded by fluctuating conditions, as well as to be flexible in how new knowledge is used in a person-centred way. Finally, the blending of a participatory workplace education with evaluation research, in which key principles from practice development were used together with critical ethnography, increased insights into how external facilitation may promote person-centred workplace learning, and how local contextual circumstances influence this effort.

Implications for practice

- Key principles from practice development, action research and critical ethnography can be blended to help access, facilitate and evaluate contextual factors
- A successful education intervention requires facilitators to take into consideration and adapt to fluctuations in the context
- A contextually tailored education intervention can promote collective decision making in a more person-centred way
- Person-centred care for older persons requires reflective considerations in the moment when surrounded by fluctuating circumstances

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