

## A model for using the VIPS framework for person-centred care for persons with dementia in nursing homes: a qualitative evaluative study

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Submitted for publication: 16 December 2010

Accepted for publication: 24 June 2011

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RØSVIK J., KIRKEVOLD M., ENGEDAL K., BROOKER D. & KIRKEVOLD Ø. (2011) A model for using the VIPS framework for person-centred care for persons with dementia in nursing homes: a qualitative evaluative study. *International Journal of Older People Nursing* 6, 227–236

doi: 10.1111/j.1748-3743.2011.00290.x

**Background.** The ‘VIPS’ framework sums up the elements in Kitwood’s philosophy of person-centred care (PCC) for persons with dementia as values, individualised approach, the perspective of the person living with dementia and social environment. There are six indicators for each element.

**Aim.** To conduct an initial evaluation of a model aimed at facilitating the application of the VIPS framework.

**Design.** Qualitative evaluative study.

**Methods.** A model was trialled in a 9-week pilot study in two nursing homes and evaluated in four focus groups using qualitative content analysis.

**Results.** Five themes emerged: (1) *Legitimacy* of the model was secured when central roles were held by nurses representing the majority of the staff; (2) The model *facilitated the staff’s use of their knowledge* of PCC; (3) *Support to the persons holding the internal facilitating roles* in the model was needed; (4) The *authority* of the leading registered nurse in the ward was crucial to support the legitimacy of the model and (5) Form of organisation seemed to be of importance in how the model was experienced.

**Conclusion.** The model worked best in wards organised with a leading registered nurse who could support an auxiliary nurse holding the facilitating function.

**Key words:** dementia, knowledge translation, milieu treatment, non-pharmacological treatment, nursing home, person-centred care

## Introduction

In recent years, the term ‘person-centred care’ (PCC) has been closely linked to the term ‘good-quality care’ (Brooker, 2004; Edvardsson *et al.*, 2008). In the field of dementia care, PCC is strongly connected to the writings of Tom Kitwood, who built on the work of Carl Rogers. Kitwood developed the concept of ‘personhood’ in response to the reductionalist biomedical view of persons with dementia. Personhood refers to the relational aspects of being human and the importance of being in an inclusive psychosocial environment with people who recognise you as a person with a unique personality and life history (Kitwood & Bredin, 1992; Kitwood, 1997; Brooker, 2004, 2007; Edvardsson *et al.*, 2008).

Translating many of the complex concepts of PCC into practice is a challenge (McCormack, 2004). Kitwood and co-workers developed dementia care mapping (DCM) to meet some of these challenges. DCM is a well-defined tool that is effective for evaluating PCC using observation, providing a basis for the reflection on and improvement of care and the further development of PCC (Brooker, 2005). However, many care providers are not in a position to implement DCM. DCM has been criticised for being costly, as it requires lengthy specialist training and resources to implement the mapping or the employment of external certified personnel (Chenoweth *et al.*, 2009).

Brooker acknowledges that PCC is not easy to describe in a straight forward manner. In the VIPS framework, Brooker summarises Kitwood’s philosophy of PCC for persons with dementia into four major elements with the acronym ‘VIPS’. The VIPS framework is intended to ensure that PCC encompasses all these four aspects, in contrast to some writers who have presented just one of them, often individualised care, as constituting PCC (Brooker, 2004, 2007). The four aspects of PCC, according to the VIPS framework, include:

- V A Value base that asserts the absolute value of all human lives regardless of age or cognitive ability
- I An Individualised approach, recognising uniqueness
- P Understanding the world from the Perspective of the person living with dementia
- S Positive Social psychology in which the person living with dementia can experience relative well-being.

Evidence base and good practice was reviewed, and six indicators for each element of PCC were identified (See Box 1).

Person-centred care, as described in the VIPS framework, involves all levels of the organisation. Establishing PCC as the value base is the responsibility of the management at a senior level in the organisation. Those responsible for setting care standards and procedures have the main responsibility for organising the individualised approach. Understanding the perspective of the person with dementia is the responsibility of each nurse. It takes the whole staff to create a positive social environment that is inclusive and offers activities adjusted to the individual needs of each person.

A great variety of educational training programs has been used to promote non-pharmacological approaches and has been found in many cases to improve the knowledge of staff in nursing homes, but the impact on work performance in the long term is still unclear (Moniz-Cook *et al.*, 1998; Lintern *et al.*, 2000; Aylward *et al.*, 2003; Turner, 2005; Wallin, 2009). This is the problem of knowledge translation, which is defined by the Canadian Institutes of Health Research as ‘a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge’ (Straus *et al.*, 2009, p. 166). It has been suggested that only 10–30% of what is taught to students attending a training course is actually transferred to their ongoing performance at work (Broad, 1997). The challenge is to enable the nurses who have understood PCC and have knowledge of milieu treatment to use it in daily care. The VIPS framework is an important step forward, but there remains a need for a model that will help health and social care professionals to apply the VIPS framework in concrete care situations.

## Aim

The aim of this study is to conduct an initial evaluation of a model aimed at facilitating the application of the VIPS framework for PCC for persons with dementia.

## Method

A model termed ‘The VIPS practice model’ (see description below) was trialled in a 9-week pilot study in two

**Box 1** The VIPS framework with six indicators for each element of person-centred care

**V** Does where we work show value and respect for the experiences of people with dementia and their families?

1. Does where I work feel welcoming to people with dementia and their families?
2. Does where I work value good quality direct care for people with dementia and their families?
3. Does where I work empower staff to act in the best interests of people with dementia and their families?
4. Is our work-force skilled in person-centred dementia care?
5. Generally are our physical and social service environments easy for people with dementia and their families to use?
6. Does where I work, know about and act upon the needs and concerns of people with dementia and their families?

**I** Are systems in place to enable staff to get to know the person and to ensure the person feels like a unique individual?

1. Do I know this person's strengths and needs?
2. Am I alert to changes in this person?
3. Do I know what personal possessions are important to this person?
4. Do I know this person's likes and dislikes and preferred everyday routines?
5. Do I know this person's history and key stories?
6. Do I know how to engage this person in an enjoyable activity for them?

**P** Have we taken time to understand the Perspective of the person with dementia and their family

1. Do I check out preferences, consent and opinions?
2. Do I try to imagine how this person is feeling?
3. Do I make the physical environment as comfortable as possible for them?
4. Am I vigilant about physical health needs that the person may not be able to tell me about?
5. If the person is showing 'challenging behaviour' do I try to understand why and what the person may be trying to communicate?
6. Am I treating the rights of the individual with dementia as important as the rights of other people in the same situation?

**S** Are we providing a Supportive Social Psychology to enable the person to feel socially confident and that they are not alone?

1. Do I help the person feel included and not 'talked across'?
2. Am I treating this person respectfully and not using a 'telling-off' tone or using labels to describe people?
3. Do I come across as warm and caring and not cold and indifferent?
4. Do people know that I take their fears seriously and not leaving people alone for long periods in emotional distress?
5. Do I help people to be active in their own care and activity as far as possible and not just do things to people without communicating with them?
6. Do I try to help the person use local community facilities and make sure that they can stay in touch with people and activities they value?

Brooker (2007)

nursing homes (NhA and NhB) and evaluated in four focus groups.

### Service settings

The two nursing homes NhA and NhB were approximately the same size and with a total staff of 122 and 110 persons. The numbers of patients were 67 and 55, respectively. All patients had dementia.

In NhA, the wards were split into 2–3 smaller units with a nursing pool consisting of three registered nurses (RN) serving the whole institution. Auxiliary nurses (AN) were administrative managers in five of these units, and RNs were managers in two of the units. NhB had a traditional form of organisation with RNs as managers in all wards.

### Focus-group sample

The directors of each nursing home were asked to send all the RNs and ANs who had occupied central roles in the VIPS practice model during the pilot study in each ward to take part in the focus groups, which included the leaders of each ward.

### Data collection

Separate focus groups for RNs and ANs were held in each nursing home. Morgan (1998) argues that the group interaction can produce data and insights that would be less accessible without the interaction found in a group. We were interested in the experience and different points of view of the nurses on the VIPS practice model.

According to Reed and Roskell Payton (1997), nurses often are more comfortable with questions that refer to their own practice and invite examples and practice recommendations. The themes in the interview guide concerned their general opinion, how the model fitted with their form of organization, experience of roles and functions, support needed and advice on alterations. The questions were used as a guide-line during the focus groups (see Box 2).

### Ethical considerations

The study was approved by the Regional Ethical Committee of South-East Norway. No patients were directly involved. We could not see that any of the patients would be affected in any negative way by the VIPS practice model, rather the opposite. The nurses were given written information about the pilot study and asked for their consent to participate and for the use of the tape recorder in the focus groups.

| Box 2 Themes and questions in the interview guide for the focus groups about their experience with the VIPS practice model |   |
|--|---|
| Theme  | Questions   |
| General opinion of the VIPS practice model   | How did you experience the VIPS practice model?   |
| Experience of the different roles in and functions of the model  | Were the consensus meetings of use to you in any way?   |
|  | What are your experience of discussing concrete care situations in relation to focus in the care? |
|  | Did you experienced the VIPS framework as a useful tool?  |
|  | Can you give any examples?  |
|  | How did the role of resource person fit with the way you are organized?                           |
|  | Were interventions decided on carried out?  |
| What kind of support was needed  | How did the expertise group fit with the way you are organized?                                   |
|  | In your opinion, did the consensus meetings have any impact on your care?                         |
|  | What kind of professional support would be the most useful in your organization?                  |
| How the model fitted with their organization   | Was it difficult to schedule and conduct the consensus meetings?                                  |
|  | - regarding attendance?   |
|  | - regarding the function of the primary nurse, focus, discussion, decisions?                      |
| Advice on alterations to the VIPS practice model   | How do you recommend meetings to be organized to have the best effect in your organization?       |
|  | What piece of advice will you give for revision so the VIPS practice model can be a useful tool?  |

### Data analysis

The focus groups were analysed using qualitative content analysis defined as ‘A research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns’ (Hsieh & Shannon, 2005). Qualitative content analysis has predominantly a naturalistic paradigm in interpretation, focuses on subject and context and deals with manifest as well as latent content in a text (Graneheim & Lundman, 2004).

As the VIPS practice model is constructed on the care philosophy of Kitwood (1997) and prior research on knowledge translation, the directed content analysis approach was chosen. The goal of this approach is ‘to validate or extend conceptually a theoretical framework or theory’ (Hsieh &

Shannon, 2005, p. 1281). Directed content analysis starts with a theory or relevant research findings as guidance for initial codes.

The tapes were listened to and the transcriptions read several times to get an overall impression. The interaction and progression of the debate in the groups were noted, as it reflects the development of a group perspective or position among a particular set of people (Reed & Roskell Payton, 1997).

The analysis began by coding statements on how the nurses experienced the VIPS practice model into the preset categories which were the elements highlighted by Kitwood (1997) and the VIPS framework: structured team work, supervision and supportive management (Kitwood, 1997; Brooker, 2007).

Next, thematic units relating to the same central meaning were identified, condensed and classified into themes and sub-themes. A theme is described as a recurring regularity or thread of meaning, an underlying meaning that answers the question ‘How?’ and expresses the latent, relational aspect of the text (Graneheim & Lundman, 2004).

Principles of inductive content analysis were used for developing a categorisation matrix within each category (Elo & Kyngäs, 2008). Finally, the themes and sub-themes were validated by assuring that the descriptions were faithful to the original content of the focus-group texts.

### The VIPS practice model

Although the elements and indicators in the VIPS framework give direction in how to perceive a situation in a person-centred manner, it is not always obvious for the average AN how to translate this into concrete care and know what to do in the situation at hand. As mentioned above, knowledge translation is a process that implies exchange and application of knowledge (Straus *et al.*, 2009, p. 166). To facilitate the process, we constructed practical guidelines and a structure for applying the VIPS framework in practice, which we termed ‘The VIPS practice model’. This model is based on regular structured team work, supervision and supportive management, elements highlighted by Kitwood and the VIPS framework itself (Kitwood, 1997; Brooker, 2007).

### Main elements, roles and functions in the VIPS practice model

Because PCC is something that characterises the relation between each nurse and the person with dementia as well as the atmosphere in the ward, the VIPS practice model focuses on the process among the staff in the ward aiming at ‘a

constant state of becoming more person-centred', and the building of a shared base of values and knowledge among the staff (McCormack, 2004, p. 38).

### Structured team work

The VIPS practice model is designed to fit in with the existing patterns of work in nursing homes as much as possible and ensure local ownership (Greenhalgh *et al.*, 2004; Pronovost *et al.*, 2008; Damschroder *et al.*, 2009). The structured team work in the VIPS practice model consists of:

- A weekly consensus meeting in the ward lasting 45 minutes–1 hour with a set structure and set roles and functions.
- A manual with practical knowledge and examples of PCC, non-pharmacological treatment related to each indicator in the VIPS framework and assessment tools for wellbeing, challenging behaviour, pain etc. The manual also contains an introduction to the main principles of PCC and description of the structure of the consensus meeting.
- A PCC expertise group common for the whole institution consisting of four experienced senior staff to support the staff holding roles and functions in the wards on request.

### Roles and functions

- The resource person (RP) is the leader of the consensus meetings. The role is held by an AN as an representative of the most numerous group of nurses in Norwegian nursing homes.
- The main function of the leading RN in the care home ward is to secure quality by giving professional support in decisions on and evaluation of the interventions.
- The primary nurse has the role as spokesperson for the person with dementia. The primary nurse knows the patient best and is the contact person for the patient's family in the staff. Most patients have ANs as their primary nurse as they are in majority.

### The structure of the consensus meeting

Each consensus meeting follows this procedure:

- 1 Presentation of the situation from the perspective of the person with dementia by the primary nurse.
- 2 The VIPS framework is used to analyse one concrete situation in the daily care for one person with dementia by assessing it in relation to all four VIPS elements. In the following discussion, 1–2 indicators are chosen and focused on.
- 3 A group discussion is held to share relevant knowledge of the person with dementia, treatment and experience of care.
- 4 Decisions are made about any new interventions that may improve the quality of PCC for the individual.

- 5 The interventions decided upon are scrutinised from the perspective of the person with dementia by the primary nurse.
- 6 Date for an evaluation of the intervention is set.
- 7 Documentation is undertaken by the primary nurse.

### Supervision and training

All the staff of the participating wards were given a brief introduction (3 hours) to the VIPS practice model and the principles of PCC. The PCC expertise group received three supervision sessions from the research team during the 9-week pilot study. The purpose was to exchange experience on how best to support the staff holding roles and functions as well as professional discussions concerning situations from the agenda in the consensus meetings. The RPs attended the first session which focused on the roles in the consensus meeting.

### Supportive management

To show active support, the management at senior level in the institution was asked to attend the introduction to the staff and one of the supervision sessions. The director was asked to secure that necessary resources were in place and time was set aside for consensus meetings and supervision. The leading RN at ward level was asked to schedule, attend and support the consensus meetings.

### Results

Because of the summer holidays some of the staff who held central roles in the pilot study were not able to attend the focus groups, but we still got an adequate sample from each institution. From NhA seven RNs and five ANs took part, from NhB four RNs and seven ANs participated. The staff in both groups were between 27 and 63 years of age in both institutions. All but one AN in NhB were women.

The focus groups' evaluation of the VIPS practice model generated four main themes. In the following sections, these four themes are presented under the elements of the VIPS practice model: structured team work, supervision and supportive management.

### Structured team work

This element got the most attention from the nurses in both nursing homes. The different themes and corresponding sub-themes with examples of meaning units with condensations are listed in Box 3 below.



| Box 3 Themes and sub-themes with examples of condensed meaning units and meaning units coded under the category of the 'structured team work' element in the VIPS practice model |   |   |   |
|--|---|---|---|
| Theme  | Sub-theme   | Condensed meaning unit  | Meaning unit  |
| <i>Legitimacy in the staff</i>   | 'Legitimacy of the model depended on roles based in the ward'   | The staff must have ownership of the consensus meeting  | 'I think the ANs feel it more as their own if they run it and I just offer my opinion'<br>'If they have not been through the process and reached the conclusion together with you, it can easily cause disagreement and we end up doing things differently'<br>'My opinion is that the RP most certainly should be someone working in the ward' |
|  | 'The structure of the consensus meeting strengthened the legitimacy of the decisions'   | Proud of mastering the structure and of the conclusions reached   | 'We were very strict in following the correct procedure to get it done. It worked very well like that, we managed it well. All of us had prepared and knew what to do. Then it worked'<br>'We refer to it as: This is what was decided in the consensus meeting!'   |
|  | The model made no difference  | The roles and functions in the consensus meeting are unnecessary  | 'In my opinion the RNs in the nursing pool are best suited to do this, it is in our job description to lead the professional nursing function in the institution'<br>'We would have reached the same conclusions without the primary contact emphasizing the perspective of the person with dementia and those other things'                    |
| <i>Facilitation of the staff's use of knowledge about PCC</i>  | 'Upholding the values of PCC and its application to daily care'<br>A forum to reach consensus and co-ordinate milieu treatment' | The staff had knowledge of PCC but found it difficult to know how to use it<br>Milieu treatment required time for planning and approval in the team | 'We have been working according to this theory for a long time, but still many of us don't apply it like this'<br>'We had to simplify the environment, it is a known fact that persons with dementia need a simplified environment'<br>(Reference to the outcome of a successful consensus meeting)   |

*Legitimacy in the staff*

This theme permeated the discussion in both nursing homes and seemed to be a decisive factor for acceptance of the elements in the VIPS practice model.

*Legitimacy of the model depended on roles based in the ward.* In the wards where the ANs had the intended roles and functions, decisions made in the consensus meeting were respected and had legitimacy. The roles of RP and primary nurse provided support and influence to the ANs.

The AN group in NhB found the role of the expertise group problematic, it felt strange to consult staff not belonging to their own ward. This strengthens the impression of the ward's importance as base of legitimacy in decisions concerning daily care, which is the model's main concern.

*The model made no difference.* This sub-theme describes the conflicting opinion of the RNs in the nursing pool in NhA. In some of the wards in this nursing home, the RNs had led the consensus meetings instead of an AN. This led to a discussion of distribution of roles, the RNs from the nursing pool stated that they were in the best position to have leading roles in the consensus meeting. This may be interpreted in relation to form of organisation. The role as expert outside of the wards of the RNs from the nursing pool may not be as compatible with the VIPS practice model as the function of the leading RNs who are managers in their wards. The opinion of RNs in the nursing pool that the structure of the consensus meeting had no effect points in the same direction.

*The structure of the consensus meeting strengthened the legitimacy of the decisions.* The ANs in both nursing homes expressed pride in mastering the structure of the consensus

meeting. The structure gave predictability and helped them reach consensus, which strengthened the legitimacy of the decisions.

The primary nurses' responsibility to document contributed to reflection, it made them more aware of the effect of the treatment:

You get more aware when you look at it this way, when you have to document that which has been agreed. I think of this lady I care for concerning the treatment that we agreed. I keep thinking of her all the time, what we could do differently when we see that something does not work.

*Facilitation of the staff's use of knowledge about PCC*

This theme describes the concession that the indicators in the VIPS framework represented values and knowledge that was familiar to the staff, but not always applied.

*Upholding the values of PCC and its application in daily care.* Before the pilot study, there had been no regular formal group meetings for consensus on care, just 5–20 minutes of overlap between shifts. The nurses in NhB gave an example of how helping each other see the person with dementia in a different light by sharing knowledge about her and discussing how she might experience the situation had made them organise care so she got more time together with a nurse during the day. The consensus meeting provided the time and focus they needed for this process.

The RNs in the nursing pool in NhA focused more on acquiring knowledge. As members of the expertise group, they expected to get more teaching on dementia and methods in milieu treatment during the pilot study.

*A forum to reach consensus and co-ordinate milieu treatment.* In NhA, the nurses gave an example of a person with dementia who was very restless at mealtimes. The staff had knowledge of what could be performed in the physical environment to make the situation better for her, but needed approval from the team as a whole to make the necessary changes in the dining room and spend the time it took to do it. The consensus meeting provided a forum with the necessary authority.

**Supervision (Box 4)**

*Support of the RP's facilitating role*

It became evident that the RPs needed support to be more confident in their role as facilitators in the consensus meeting. In NhB, the leading RNs in the wards realised the RPs needed more supervision and asked them to attend all the expertise

**Box 4** Themes with examples of condensed meaning units and meaning units coded under the category of the 'Supervision' element in the VIPS practice model

| Theme  | Condensed meaning unit                          | Meaning unit   |
|--|---|--|
| <i>Support of the RPs' facilitating role</i> | The role as RP required support and supervision | 'I would have felt more confident, it would have been nice if two of us had been to the supervision sessions and received the same training' |

group's supervision sessions. In NhA, the RNs in the nursing pool took over the function if the appointed RP did not feel confident. One RP in NhA said: 'I am actually the RP, but the RN from the nursing pool has been there as RP all the time'. It was also reported that it would have been helpful to the RPs if the rest of the staff had had more information about the model.

**Supportive management (Box 5)**

*The leading RN's authority in support of the legitimacy of the model*

In the nursing home with leading RNs in all the wards, her presence gave authority to the consensus meeting as a synergy effect with the RP's role. The nursing home with ANs as administrative leaders did not always have the authority required, even with the co-operation of an RN from

**Box 5** Themes with examples of condensed meaning units and meaning units coded under the category of the 'Supportive management' element in the VIPS practice model

| Theme   | Condensed meaning unit                                   | Meaning units   |
|---|--|---|
| <i>The leading RN's authority in support of the legitimacy of the model</i> | Authority is required to establish the model in the unit | 'We depend on the leading RN to authorize that "this is how it is decided", but we are not dependent on her for running the meeting, the RP can do that'<br>'I struggle, the responsibility is all mine and hers. How do we get the others to go with us on this?'<br>(A ward without a leading RN) |

the nursing pool one of the ANs still had difficulty establishing the roles in and functions of the model. The management at a senior level in the organisation, the director, was only mentioned after some probing and not dwelt on in the focus groups.

### Difficulties connected with the model

It was hard to find time for the staff to read and get to know the VIPS manual. The documentation represented a challenge in both nursing homes because the software programs were difficult to access. In NhB, the staff solved this by using pen and paper until the stage when the interventions were evaluated, then they used the software program. None of the wards managed to organise more than four meetings in the 9 weeks the pilot study lasted. It was suggested that there should be a schedule of meetings for the whole term and that regular staff should be paid if they had to stay on or come early to attend.

### Discussion

In sum, our findings suggest that the VIPS practice model worked. The consensus meeting emerged as the corner stone. It provided a forum for planning treatment that required co-ordination and co-operation. Use of the indicators in the VIPS framework to analyse care situations helped the team apply PCC in a practical way. An AN in the role of internal facilitator (RP) backed by the authority of the leading RN based in the ward secured the legitimacy of the model with the staff. Furthermore, the findings suggest that RPs need more support in the form of supervision for themselves and a more comprehensive introduction should be given to the rest of the staff.

The finding concerning legitimacy might be related to the internal facilitation function, comprising an opinion leader and formal leadership. Kitson *et al.* (1998) found that someone belonging to the ward had to take over the facilitating function for a change in working methods to succeed and be sustained. Together with the finding that the consensus meeting facilitated the use of knowledge about PCC, it resembles Titchen's model of facilitation, which emphasises learning from practice and the co-creation of new knowledge through critical reflection with dialogue between the practitioner and an experienced facilitator (Harvey *et al.*, 2002). The ANs in this study were not experienced facilitators, a fact which they felt strongly about and they duly reported a need for more supervision. This need might be met in a 'hybrid' model where facilitators from outside work with internal facilitators to develop their skills and

enable them for the function (Harvey *et al.*, 2002; Rycroft-Malone *et al.*, 2002).

The RNs in the nursing pool diverged from the majority in their evaluation of most elements in the model. One explanation might be the context's receptiveness for change, which seems to be the decisive factor in the success of the implementation of any change (McCormack *et al.*, 2002; Greenhalgh *et al.*, 2004; Rycroft-Malone *et al.*, 2004; Cummings *et al.*, 2007). The model might not fit with their context and present role as experts called in when difficult situations arose in the wards (Visser *et al.*, 2008; Damschroder *et al.*, 2009). However, their request for more teaching poses a relevant question: what level of initial knowledge of PCC and milieu treatment in the staff is a prerequisite for the model? It is obvious that staff cannot use knowledge they do not possess, the question is rather how knowledge is internalised. Our findings indicate that facilitating the sharing of knowledge and practical application is effective. Discussions might also make the nurses look for knowledge in easily available sources, like the VIPS manual. The values of PCC can be passed on and embedded in the staff by reaching a consensus about treatment and evaluating the effects. The reason why the expertise group did not function in the facilitating role might be because it interfered with this internal process in the staff.

### Choice of methodology, validity

The discussion in a focus-group interview reflects the ongoing discourse in the group and in the profession (Reed & Roskell Payton, 1997). As this is what we were interested in, this approach was an appropriate choice. The focus groups were conducted in the work place to provide a familiar setting and for practical reasons. Separate groups for RNs and ANs were used to avoid anyone 'pulling rank'. The fact that the researchers who conducted the focus groups also conducted the supervision during the pilot study might undermine the study because of the researchers' preconceptions and because the participants might have been reluctant to criticise. The critical feedback from the RNs in the nursing pool allows us to believe that the participants found the researchers encouraging and that they welcomed criticism.

The coding was carried out by the lead researcher. In the course of the iterative analysis process, one of the supervisors (MK) played the role of 'external inquisitor' by reviewing and questioning the logic and consistency of the coding and the tentative conclusions drawn from the data. Regarding confirmability, the results were discussed with the other



researcher who took part in the pilot study and the interviews.

Through these steps, consensus regarding the analysis and results was achieved.

## Conclusion

The evaluation of the pilot study indicates that facilitating roles based in the ward are crucial for the working of the model to apply the VIPS framework. More supervision should be given initially to staff holding these roles. The expertise group will be removed from the revised model. The VIPS practice model will be used with focus on patient outcome in a randomised controlled trial in 2011.

### Implications for practice

- The model offers a way of translating the concepts of PCC into daily care in nursing homes.
- The model can build up a shared base of knowledge and the values of PCC in the team.
- The model requires little change in the organisation and fits within normal resources.

## Acknowledgement

The study was funded with funds from Research Council of Norway. Thanks to Marit Mjørud for taking part in the data collection.

## Conflict of interest

There is no conflict of interest. The funders have not been involved in any stage of the study, in neither design, data collection, management, analysis nor interpretation of the data.

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