Learning from a Successful Process Evaluation in Care Homes

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Abstract

Introduction

Process evaluations are increasingly used in parallel with Randomised Control Trials (RCT) to inform the implementation of complex health interventions. This paper explores the learning accrued from conducting a process evaluation within the Falls in Care Homes Study (FinCH), a large UK RCT.

Methods

In the FinCH study, six purposively sampled care homes provided data for the process evaluation which followed a realist approach. In this study researchers kept written diaries of their experiences in completing the interviews, focus groups and observations. We have reflected on these and present the main themes for discussion

Findings

Care home staff were enthusiastic to participate in the process evaluation but researchers found it difficult to collect data due to staff not having time to take part, environmental factors such as no space for focus groups and low levels of research understanding. Researchers found that the expectations of the process evaluation protocol were often unrealistic due to these limitations. Flexible and pragmatic approaches, such as interviews in place of focus groups enabled data collection, but required a reduced sample size and length of data collection to be accepted by researchers.

Conclusion

To enable care home staff to participate in successful process evaluations, researchers should build flexibility into research schedules, spend time building trust, collaborate with all levels of care home staff prior to data collection, increase research capacity in care home staff and co-design research projects.

Background

Process evaluations (PE) are increasingly used alongside Randomised controlled trials (RCT) in applied health and social care research. Using complementary methods (interviews, focus groups, observations) they provide additional insight which aids interpretation of RCT findings and/or guides future implementation [1]. In the recent Falls in Care Homes (FinCH) RCT a nested process evaluation was used to capture local examples of the delivery of a falls prevention tool [2].

The heterogeneity of the UK care home sector makes such process evaluation insight important in planning for future delivery in care homes which might vary in size, shape and operation. The UK care home sector supports more than 421,000 individuals [3] in homes managed by public, private and the charitable organisations, and in homes which may or may not include onsite nursing provision.

Undertaking a process evaluation in a care home, however, is not without its logistic challenges. Care homes are not uniformly-ordered health care settings, but are rather individuals' homes where comfort and familiarity are important and need to be respected. Whilst research in care homes is increasing many care home managers, staff and residents remain unfamiliar with research processes and methods; even more so for process evaluation research where methods might be unstructured, iterative and time consuming for both staff and resident.

The FinCH Process Evaluation

The findings of the FinCH PE are reported elsewhere, here we reflect upon the logistical challenge of generating process evaluation data in care home settings. Table 1 describes elements of the FinCH PE.

Table 1: Process evaluation in the FinCH RCT.

Element of PE design	FINCH Process Evaluation
Approach	• A realist evaluation managed independently of the FinCH trial. • Limited contact between PE and RCT to ensure that outcomes were distinct. [1]. • Programme theories were developed to describe delivery of GtACH in 'ideal circumstances'.
Settings	• Iterative, theoretical sampling to test the programme theories in a variety of different care home settings. • Heterogeneity of the sample was used to provide an opportunity to identify the barriers and facilitators for implementation. • Care homes were purposively selected, reflecting a mix of different home types, ownership, sizes and registrations.
Data Collection	• Data collected outside of RCT processes. By separate, autonomous research team. • Interviews and focus groups involving all levels of care staff. Interview and focus group data collected immediately following GtACH training, and after 3 months of using the GtACH.

	• Observation were made of intervention use and reflexive diaries were kept by PE researchers. • Documentary review of intervention paperwork and its use in participating care homes. • Trial outcome data for homes involved in PE was reviewed following PE data analysis.
Data Analysis	• Thematic, framework analysis of interview and focus group transcripts. Observation and reflexive data were used to add contextual depth to the analysis. • Descriptive statistics for each home. • Context –Mechanism-Outcome statements (CMOs) for each home were generated. • PE data analysed outside of RCT process.
Synthesis	• Care home specific and recurrent patterns across all care homes identified. • Programme theories revised in line with actual practice, recommendations for future GtACH implementation.

The Data Collection stage of the PE was influenced by three key logistical areas which might be distinctive about researching in care homes:

Staffing

A strength of the PE was the composition of the team, composed of healthcare practitioners with experience of working in the care home environment. This experience helped in the design of the interview schedules (different schedules for management, care home staff, healthcare staff and residents), and when conducting focus groups or interviews with staff or residents. This strength extended to the analysis process, with a team of therapists, nurses, and Patient and Public Involvement Partners developing the themes.

The experience of the team assisted in the development of good working relationships with the care homes. However, this did not deflect from everyday issues that these homes face. We found on several occasions that routine care, staff illness/absence or resident emergencies meant that there were insufficient staff to conduct research focus groups. This was exacerbated in smaller care settings (with fewer staff) and in those homes where some staff declined to participate in the study. The care homes used within the PE did not operate with an excess of staffing, which left little availability for staff to step away from resident care to participate in interviews and focus groups. These care homes were private businesses providing a high quality, commercial service and maximising the comfort of their residents. Removing several staff members from direct care in order to participate in a focus group could be perceived by the residents as negatively impacting upon the service that the care homes provide.

However, the care homes were keen to engage with the PE and despite the challenges, 11 focus groups were conducted. One valuable lesson learnt was that focus groups could easily be converted to one to one or small group interviews, and this mechanism was frequently adopted. It is a strategy that others designing qualitative research in care homes might consider at the planning stage.

Within research trials in the UK who use publicly funded (NHS) services, it has become increasingly common for 'Excess Treatment Costs' to be granted to these services [4]. This allows for managers of participating services to pay to release staff to participate in the research without a loss to standards of care. This financial support is specifically designed to meet costs in the NHS, is not available to Care homes as they are not providing NHS services [5]. This may have contributed to difficulties for homes participating in focus groups, as these represented a significant burden on their staffing levels on any given day.

Further staffing burden was sometimes created through the separate nature of the PE and RCT arms of the trial. This meant that, due to RCT researchers being blinded, and the PE only taking place in intervention homes, all PE and RCT home visits needed to be kept separate. This added complexity to arranging visits to the homes and an extra time burden for the homes involved.

Timings

Care homes are busy places which generally operate a structured day. The researchers openly acknowledged that resident care was the priority, and that we were guests within the environment. This necessitated working around staff routines and resident needs. We found that staff interviews could not take place before 10.30am or at lunch or tea times. Even out of these periods staff were often anxious to return to their job and/or were distracted during interviews and focus groups, especially when care demands were high. Even at the end of their shift the pressure of completing necessary documentation might occupy staff and delay any interview or focus group.

To accommodate staff shift patterns we quickly recognised the need to be flexible about the timing of research visits and often data was collected late at night or early in the morning before shifts started. On these occasions staff were evidently providing data outside of their normal work time, but it was unclear whether they were being paid for this additional presence at work. However, none of the staff appeared aggrieved by the request to participate in data collection in their own time. Balancing a need for well-produced data, whilst recognising the (time) needs of staff requires researchers to be flexible and again this needs to be considered when planning qualitative data collection in care homes.

Flexibility was enhanced by researchers being open to collecting data from a range of sources. If focus groups had to be abandoned on the scheduled visit then alternative types of data were collected, such as interviews, observations or reviewing of care records. The most challenging situation arose with collecting data from a distant site where over-night stays were necessitated. There were occasions when these visits could not be conducted due to adverse weather. In these situations, researchers revised the data collection from face to face focus groups to one to one telephone interviews.

Environment

We often found it difficult to locate a suitable (private) space to conduct focus groups and interviews. A private space is important to aid social interaction and so that staff can feel certain that what they are saying will be in confidence [6,7]. However, care homes are busy places which often have limited private space suitable for interviews and focus groups. Indeed, in three (out of the six) care homes interviews and focus groups took place in dining rooms, lounges, thoroughfares, or shared office space. In these spaces there were frequent interruptions by residents, noise from activities and sometimes other staff present using computers. We had no control over who was using the rooms, or about who came and went; in some settings this type of interruption significantly affected the dynamic of group discussions and/or impacted upon the perception of anonymity for those who were participating. This observation highlighted the importance of discussing with care home management whether rooms can be allocated for data collection at the start of the study.

Considerations for Researchers

On the basis of learning acquired from conducting this qualitative study recommendations have been highlighted in Table 2 for others planning to conduct qualitative studies in the care home environment:

Table 2 Considerations for researchers planning qualitative studies in care homes

Recommendations	Considerations for researchers
Design research protocol with care home culture in mind	• Collaborative design of the process evaluation (not only the RCT) using care home staff (not only management) will help to pre-empt and avoid issues prior to beginning the study [8]. This includes discussions regarding suitable rooms and the availability of staff for focus groups. • Flexibility in project timings and data collection appointments should be considered at the design stage of the protocol as some challenges cannot be foreseen. • Understand that whilst the care home industry wants greater involvement in research [4], this will initially need greater support from research staff which should be reflected in research budgets and design.
Encourage a supportive research environment	• Involving all staff (not only management) in preparation for the research and get 'buy in' from all levels of staff to be included in the study • Spend time building rapport and trust with home staff, prior to data collection visits, which can aid free exchange of experiences and enrich data collection[9] • Consider providing financial support to allow managers to free the time of their staff to participate.
Communication	• Where a process PE is embedded in a larger RCT, clear communication between the care homes and the PE team is needed to limit the impact of RCT and PE visits to the care homes. • Give sufficient notice on site visits, researchers to acknowledge the number of visits being made by the whole of the research team. • Although it is suggested that PE should not provide findings concurrently with the study in case it impacts on the validity of the study [1], there needs to be a discussion between the two arms of the study regarding ways to disseminate issues that affect the whole study.

Above all, research teams should understand the care home environment and the impact that accessing staff for interviews and focus groups can have on their working environment. Good quality data can be obtained but traditional approaches such as large focus groups and lengthy interviews may not be appropriate for this population. Research teams need to be flexible in their approaches or investigate novel methods to explore how complex interventions are implemented within care homes, including technology and online based techniques.

Conclusion

There is a growing appetite within the care home community for involvement in health research. However, this can present researchers with methodological challenges that arise from care homes

having a lack of experience of research. Care homes are principally commercial businesses, whose immediate priorities are not around research but in providing care for their residents. This sometimes makes data collection unpredictable and requires researchers to be able to modify their skills and techniques. If researchers can adapt their skills and maintain flexibility, it is possible for them to gain access to the right participants and build trust. This in turn, enables care home staff to share their thoughts and experiences. Essentially, finding ways of successfully engaging care home staff in PE is vital to enable us to fully understand how complex interventions are implemented within this environment.

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