

Using FRAME to adapt an evidence-based dyadic intervention program for people living with dementia in residential aged care: A pilot feasibility study

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[Correction added on 10 July 2024, after first online publication: The spelling of the name of the authors, Helen Radoslovich and Natalie Galligani, has been amended.]

Abstract

Introduction: The purpose of this study was to examine the feasibility of adapting and translating an evidence-based occupational therapist-delivered program shown to be effective in the community to residential aged care (RAC). The program aims to improve quality of care and quality of life for people living with dementia and the wellbeing of the family care partner.

Methods: This study took place in a not-for-profit RAC home in Adelaide, South Australia. Mixed methods, specifically questionnaires, activity logs, focus group, and one-on-one interviews were used to evaluate the feasibility of the program implementation. Staff working in the participating home, occupational therapists trained to deliver the program, and residents and their family carer partners were included. Quantitative data were analysed using proportions, means, and standard deviations. Qualitative data were analysed using a thematic approach.

Consumer and Community Involvement: This study was conducted together with a consumer (person living with dementia) and a carer representative (family member of someone residing in RAC). These representatives provided input towards the study design, interpretation of study data, discussion of results, and recommendations for future consideration.

Results: Small changes to the program improved feasibility and acceptability for delivery in RAC. While the care home staff required added support during implementation, the intervention therapists felt that the program could be delivered in this setting. Family care partners of residents with dementia felt that the program may be better suited if provided upon entry to RAC or in early stages of dementia.

Conclusion: Adapting a community-based dementia care program to RAC can be safe and feasible. Program adaptations are necessary for feasibility. Further adaptations and evaluations of associated outcomes (related to residents

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with dementia and their family care partners) are needed to assess the program effectiveness in larger scale.

Plain language summary: Spending quality time with family members in residential aged care is important. However, many struggle to know what to say or do when visiting a family member who lives with dementia. Programs that teach families about how to communicate with people living with dementia, how to support them to take part in important everyday living activities, or how to understand why changes in behaviours may occur have not been available in residential aged care. This paper describes how we adapted one such evidence-based program from community to residential aged care settings. We consulted with people living with dementia, carers, and families and found that the program could also be valuable in this care setting. Residential aged care staff described how the program is very different to what is usually available in residential aged care, but they were optimistic that with the right support, it could be a valuable way to support residents with dementia and their families. Family members of residents with dementia and therapists delivering the program felt that residents in early stages of living in residential aged care and/or early stages of dementia could benefit the most from these programs. We found that including family members in the intervention process can be useful and empowering for families and residents. Future work should also focus on involving other staff members caring for residents in the process. Communication between staff and families is the key for program delivery and success and treating each person as an individual.

KEYWORDS

activity participation, carer, dementia, feasibility study, occupational therapy, quality of life, reablement, residential aged care

1 | BACKGROUND

Residential aged care (RAC) homes provide individuals with care that they need to meet their basic needs and to maintain their quality of life (QoL) (Department of Health Australia, 2021). These homes cater for almost 20% of the population aged ≥ 80 years in Australia (OECD Health Statistics, 2021). Up to 80% of all residents are estimated to experience a level of cognitive impairment, and approximately two thirds are estimated to have a formal diagnosis of dementia (Caughey et al., 2020; Dyer et al., 2018). In 2021, the Royal Commission into Aged Care Quality and Safety described RAC as typically being an environment of dependency, isolation, and disengagement (Royal Commission into Aged Care Quality and Safety, 2021). The Commission identified several systematic issues to the failure to meet the needs of people living with dementia and their family care partners (Royal Commission into Aged Care Quality and Safety, 2021). These issues included lack of health

Key Points for Occupational Therapy

- Occupational therapists are underutilised in RAC homes. Evidence-based occupational therapy interventions in this setting are needed.
- Adapting evidence-based community programs to RAC fills a major gap in existing services.
- Programs that engage family care partners in therapy can improve family relationships and quality of life for both residents and family care partners.

professionals trained in evidence-based programs targeted specifically for people living with dementia and poor understanding that people living with dementia can

improve in function and wellbeing (Royal Commission into Aged Care Quality and Safety, 2021).

Several programs that aim to improve independence and engagement for residents in RAC have been developed and evaluated (Brooks et al., 2018; Hayward et al., 2022; Möhler et al., 2018; Rahja et al., 2022). Involving families in care following admission to the care home can enhance QoL, communication, and relationships between family care partners and care home staff (Hayward et al., 2022; Rahja et al., 2022). However, there is uncertainty around how to best involve family care partners to produce the most benefits for residents with dementia (Hayward et al., 2022). Programs that aim to improve family care partners' wellbeing following RAC placement have shown benefits in terms of reduced guilt, distress, and grief, but they primarily focus on providing education about dementia and emotional support to the family care partners (Brooks et al., 2018). These programs may not address the needs of the person living with dementia. Most programs are tested in controlled settings, and less is known about how they work if implemented within current practices using existing resources.

Care Of People with dementia in their Environments (COPE) is an evidence-based program that uses occupational therapy skills (such as problem solving, environmental adaptations, and activity engagement) to identify strategies to address the needs of a person living with dementia and their family care partner (Gitlin et al., 2010). The original program consists of up to 10 occupational therapy and two nurse contacts over a period of up to 4 months (Gitlin et al., 2010). The occupational therapist works with the person living with dementia and their informal care partner to identify areas of concern. Care partners are educated to problem solve different approaches around modifying their communication, the living environment, and how to encourage participation in everyday living activities for the person living with dementia. The care partner is also educated on how to engage the person living with dementia in enjoyable activities based on their level of cognitive and functional ability. A nurse is involved to provide support for medical management and related care. Earlier research suggests that COPE can have positive impact on independence and participation in everyday living activities for individuals living with dementia (Clemson et al., 2020; Gitlin et al., 2010). Care partners have reported improved wellbeing and confidence to continue to provide care (Gitlin et al., 2010; Rahja et al., 2020). However, COPE was designed for and evaluated with community dwelling individuals living with dementia, and no such program has been available in RAC homes in Australia. We hypothesised that evidence-based

community-based programs, such as COPE, could be adapted and successfully delivered in RAC homes.

2 | METHODS

This study was conducted between August 2021 and December 2022. The purpose of this paper was to report the process and results of a pilot feasibility study to adapt, test, and translate the COPE program to a RAC home. Modifications to evidence-based programs are common when implemented in real life (Wiltsey Stirman et al., 2019). Yet, when such programs are implemented, the what, why, and when these modifications are made are rarely documented (Wiltsey Stirman et al., 2019) even though the adaptations or changes within the program itself or in its delivery process may impact the outcomes (King et al., 2020).

We used the updated Framework for Reporting Adaptations and Modifications-Expanded (FRAME; Wiltsey Stirman et al., 2019) to report adaptations made on the COPE program to be translated into RAC. FRAME has been recommended for use when implementing evidence-based programs in real-world contexts. It allows researchers and practitioners to systematically document, evaluate, and report adaptations made to ensure transparency, fidelity, and effectiveness (Wiltsey Stirman et al., 2019). The updated FRAME facilitates reporting of (1) when and how in the implementation process the modification was made, (2) whether the modification was proactive/planned (i.e., an adaptation) or reactive/unplanned, (3) who decided that the modification should be made, (4) what was modified, (5) at what level of delivery the modification was made, (6) type or nature of context or content-level modifications, (7) the extent to which the modification was fidelity consistent, and (8) the reasons for the modification, including (a) the intent or goal of the modification (e.g., to increase fit within a specific setting) and (b) contextual factors that impacted the decision (Wiltsey Stirman et al., 2019).

Our secondary aims were to describe the experiences of the dyads participating in the program, the potential outcomes associated with the delivery of COPE in RAC, and to determine if the program is feasible in this setting.

Ethical approval for this study was granted by Southern Adelaide Clinical Human Research Ethics Committee, Adelaide, Australia (ID: 2021/HRE00404).

2.1 | Positionality statement

MR and KL are occupational therapists and clinical academics with experience and expertise in implementation

research. MC is a rehabilitation consultant with expertise in implementation research within health and aged care settings. AP and HR are consumer advocates with specific focus on dementia and care partner perspectives. NG and NB are community-based occupational therapists who have been trained to deliver the COPE program.

2.2 | Setting

This study took place in a not-for-profit RAC home in Adelaide, South Australia. The home consists of 150 bedrooms, a memory support unit, health and wellness centre, and several other self-care and spiritual opportunities for residents.

2.3 | Participants

Occupational therapists employed by the participating organisation and experienced in working with people living with dementia were invited to participate as intervention therapists. Included occupational therapists agreed to be trained in the COPE program and to complete data collection forms as part of the research.

RAC home staff who provide care and support for residents (related to, e.g., their everyday living activities, exercise, rehabilitation, or leisure activities) were invited to take part in a once-off focus group conversation to discuss their perceptions about how the program could work in RAC (i.e., the program feasibility). Administrative or clerical staff who do not engage with residents daily were excluded from this focus group.

Residents with a diagnosis of dementia or probable dementia recorded in the file and a family member/friend (from now on referred to as care partner) aware of this diagnosis were eligible to participate. The resident had to live in the participating home and have the care partner visiting them regularly and/or providing them regular oversight, social support, or care. Exclusion criteria was that the care partner raised no areas of concern that warranted addressing as part of this program. Residents and/or their care partners were first approached by the RAC home staff and given a brief explanation and flyer about the study. If agreeable, their details were shared with the researcher (MR) who contacted the potential participants, provided more detailed information about the study, and obtained relevant consent. Potential participants (residents living with dementia) who were deemed unable to consent for themselves due to cognitive impairment were asked for verbal assent (i.e., an agreement to participate of someone who is not able to give legal consent), if they were capable. For these

participants, written proxy consent was also obtained from a person appointed to make medical/health related decisions on their behalf.

2.3.1 | Sample size justification

We aimed to recruit up to 10 participant dyads. This number seemed feasible to allow completion of the pilot over the intervention program period and to test some planned program adaptations, recruitment, and data collection methods. The sample size was not powered to detect significant changes in the secondary measures.

2.4 | Data collection

We used the expanded FRAME to record adaptations made to the original program. The data for program structure-related adaptations (e.g., session length, session number, session participants, and mode of delivery) were derived from meeting minutes, researcher notes, and intervention therapist reports. Reflection notes were completed by the research staff noting down any variations made to the program and any other relevant aspects identified by members involved in this study that were related to the program implementation.

The feasibility of the program was determined using the following criteria: recruitment (% approached who agreed to participate), completion of the intervention (retention), number of sessions, overall adherence, and any modification in the program delivery (optimisation of program structure for this setting). An earlier implementation study in Australia has reported variability in the COPE protocol delivery compared with its original format (Gitlin et al., 2010). For the RAC setting, we estimated between five and seven sessions with a therapist, and $\geq 60\%$ adherence would be acceptable. We targeted for a 50% recruitment rate and 80% retention rate (with estimate 20% drop out).

We completed a once-off focus group conversation with staff members who met the study inclusion criteria and wanted to take part in the conversation (guide included in the [supporting information](#)). We planned to complete the focus group conversation prior to any participants dyads were recruited in order to understand the staff perspectives regarding the program feasibility before introducing it to the RAC home.

The research occupational therapists were asked to evaluate their own practice using a fidelity checklist to measure the extent they delivered the program according to its protocol. The fidelity checklist was a shorter version of the one used in the Australian

implementation study (Clemson et al., 2020) and has not been validated for use. The checklist consisted of Likert scales and covered process outcomes related to the COPE program, the extent the program was delivered according to protocol, and participant engagement with the program. Once they had completed three programs with participant dyads, therapists were also asked to complete an implementation behaviour questionnaire (DIBQ) (Huijg et al., 2014), which asked about the delivery of the program.

A pre-and post-evaluation was completed with participant dyads. A validated five-item scale, a measure of engagement (Albert et al., 1996), was used to explore changes in activity engagement with the resident living with dementia. The measure asks the care partner to rate the person with dementia's engagement in leisure activities on a scale from 1 (*never*) to 3 (*often*). One item is reverse coded, and scores are calculated by summing across and then dividing by number of items. Higher scores indicated greater engagement. The informal care partner wellbeing was assessed using the Perceived Change Index (Gitlin et al., 2006). The index is a validated 13-item questionnaire that asks the care partner to rate each question related to their wellbeing/coping on a scale from 1 (*got ten much worse*) to 5 (*improved a lot*). These outcome assessments were also used in the original randomised control study (Gitlin et al., 2010) and the Australian implementation study (Clemson et al., 2018; Clemson et al., 2020).

The validated 15-item QoL-AD instrument specific to RAC homes was used to measure change in participant QoL (Edelman et al., 2005; Logsdon et al., 1999). The instrument asked details about the participating resident's ability to take care of themselves using a 4-point scale (*poor, fair, good, and excellent*), with higher scores indication better QoL (Edelman et al., 2005). The QoL-AD could be completed by the resident or a proxy (a person on behalf). The proxy version was used by all participants in our study.

All participant dyads were also invited to take part in semi-structured interview about their experiences of participating in the program (guide included in the [supporting information](#)). During the interview, they were asked to rate the program on a Likert type scale (1 = *not valuable*, 2 = *somewhat valuable*, 3 = *valuable*, and 4 = *very valuable*). Administrative details (e.g., time spent planning, training staff, and setting up the program, as well as staff time related to program delivery) and progress notes were collected throughout.

2.5 | Data analysis

The data for the feasibility and participant outcomes component of the study were analysed using proportions and means and standard deviations. This included proportion of approached people who agreed to participate, percentage of participants who completed the program, mean number of program sessions completed, and number of participants who dropped out. Modifications made to the COPE program were also recorded.

A pre- and post- comparison was completed for participant specific outcomes. All quantitative data were explored looking at changes at an item level, as well as the total change score for each scale. All interviews and the focus group discussion were audio-recorded, transcribed verbatim by a third-party transcription service. The primary analysis was complete by the first study author (MR) using a thematic approach (Braun & Clarke, 2006). The first step included familiarisation with the data. Initial codes were then generated for as many topics as possible. Next themes were generated based on sorting of the initial codes in higher level topics. These themes were reviewed together with another study author (KL), and data revisited to ensure we were happy with the codes and themes generated. The theme names were then refined to ensure they accurately captured the key messages from the interviews that addressed our research questions. Finally, quotes that encapsulated the essence of each theme were selected and are presented in this paper to illustrate the discussed concepts. QSR NVivo software Version 14 was used to aid with the analysis. Any quotes from interviews or focus group discussion have been coded as follows: intervention occupational therapist (OT), care staff focus group participant (CW), and resident's care partner (CA). When presenting quotes from participants, we have, where needed, added words in square brackets ([]) for contextual clarity.

3 | RESULTS

Recruitment took place between July and December 2022. Five participant dyads took part in this feasibility study. Two community occupational therapists employed by the participating organisation were trained to deliver the adapted COPE program. That is, these therapists did not commonly practice in the RAC home where they delivered the programs. Seven RAC home staff members took part in the focus group discussion.

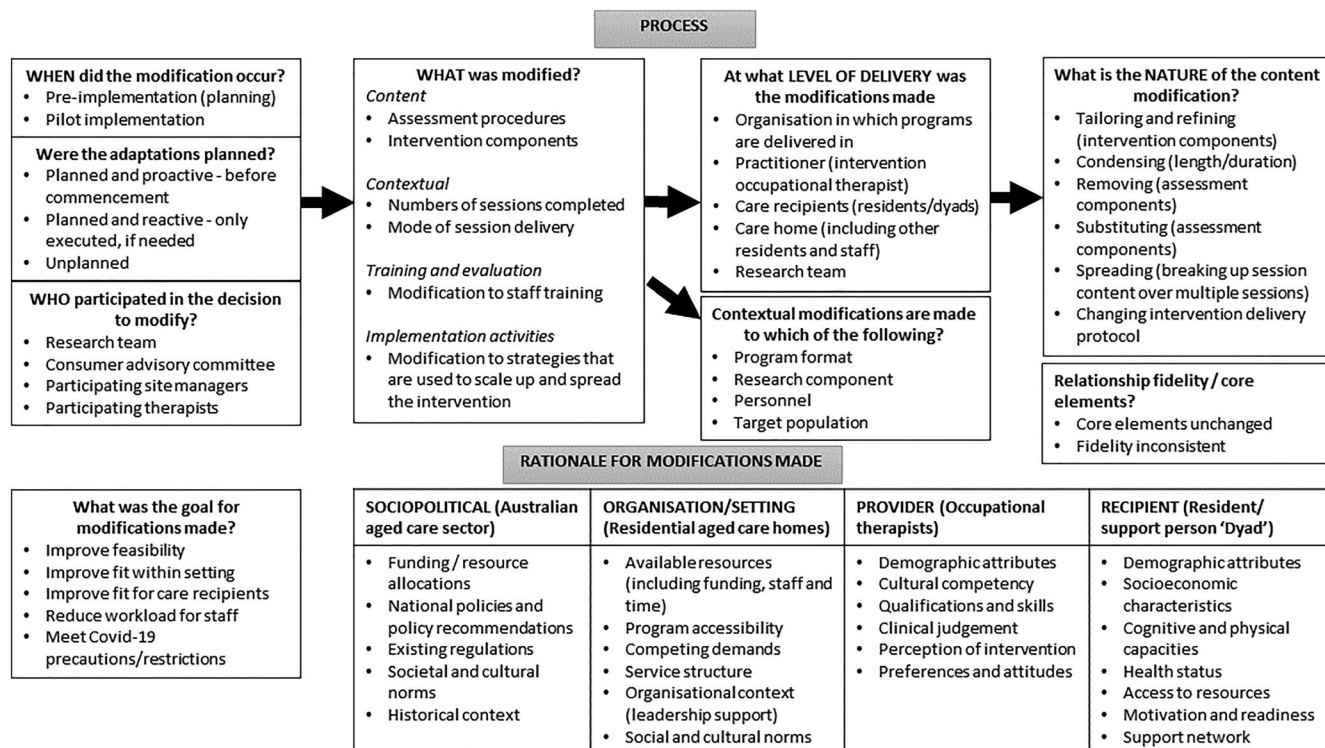


FIGURE 1 Program adaptations made using the update Framework for Reporting Adaptations and Modifications-Expanded (FRAME)

3.1 | Program adaptations

Figure 1 shows the adaptations made using the modified FRAME. Several adaptations were discussed and agreed on in the planning (pre-implementation and pilot) phase. These discussions were conducted with researchers, care home managers, intervention therapists, and the steering committee (which as well as the investigators, included consumer, and family care partner representatives). The program content-specific adaptations were decided by the steering committee, and contextual adaptations (planned and unplanned) were decided by the researchers and participating therapists. The adaptations included changes to the participant assessments and intervention components. For example, they included removal of the Allen cognitive level screen (Allen et al., 2007), as this requires specific training and resources that are not readily available. The nurse specific component of the program was also removed. RAC homes have nurses and care workers present 24/7 who monitor potential health and medical issues related to hydration, continence, pain detection, and medications. The intervention therapists were advised to liaise with and check case notes for any health and medical related issues, if they were concerned. Acknowledging the competing demands on therapists in RAC, we also explored how the COPE program could be delivered in fewer

sessions. Amendments were made so that the therapists could complete the initial assessment in one session (instead of two), they could focus on only one or two problem areas (instead of three), and they could generalise the program learnings in one session (instead of two). Another notable potential change discussed was that the 'dyad' may become a 'triad', meaning that a care home staff member may become an additional study partner for the resident. The researchers also planned some adaptations for training and evaluation of the study outcomes. Training was condensed and evaluation forms modified to suit the current setting (removal of questions related to community living and/or adapting these to reflect the RAC setting). A QoL measure was added in the participant outcome assessment battery as recommended by a recent review (Rahja et al., 2022). Modifications were made at all delivery levels. Some of the underlying reasons for the modifications made were to improve uptake and feasibility, to improve fit within RAC setting, and to meet Covid-19 precautions and restrictions.

3.2 | Program feasibility

Eight residents (and their families) were initially identified as potential participants. Of the eight potential resident/family care partner dyads, five (62.5%) agreed to

TABLE 1 Key program delivery components

| Program component | Outcome |
|---|-------------|
| Average number of consultations completed (range) | 4 (3–6) |
| Average overall time spend delivering the program (minutes, SD) | 196 (42.04) |
| Average total administrative time per program (minutes, SD) | 122 (42.80) |

participate, which we considered acceptable. One dyad was deemed not suitable after initial identification (due to other medical concerns) by the RAC staff. One dyad declined to participate as the care partner was not visiting the resident often enough, the other dyad did not feel that the program was for them.

Key program delivery components, including number of sessions and average time spend delivering the programs, are presented in Table 1. All participant dyads completed their respective programs (100% retention rate). The average number of consultation sessions was 4 (range 3–6). However, some of these consultations were brief (15 min) phone conversations. For each program, the average time spend with participants was 3.27 h (range from 2.5 to 4 h).

The focus group was held prior to recruiting any participant dyads. This meant that we could ask the staff participants about their perceptions about the program feasibility before it was introduced in the RAC home. Seven RAC staff took part in the focus group discussion. Staff consisted of two physiotherapists, two care managers, one occupational therapist, a registered nurse, and a wellness and lifestyle manager. The initial thoughts were that the program sounded ‘good in theory’ (CW3), but the staff ‘can’t see it feasibly working’ (CW5). The primary concerns were related to time and resources. The focus group members discussed the time requirements in detail with regards to current workload and found it hard to comprehend how the program would work with current resources available. An extract from this discussion is included below.

... Like I could do, you know, one resident for 10 sessions and then do another like, do you know what I mean? ... But I don’t know about multiple ... an hour a session. (CW2) And it’s family focused, I guess that has to be taken into consideration. (CW4) It’s a fair chunk of your day. (CW1)

The program was considered vastly different from the current occupational therapy practice in RAC, which was described as having a greater focus on pain management. The participants discussed that including programs such as COPE in standard care would likely require support from the top-down, even in form of a new job description. The discussion went as follows:

I think there’d be something that would have to come from head office, rather than site by site. (CW6) Yeah. Absolutely. (CW1) Um, an organisational implementation as such, um, if they’re wanting, you know, the OTs to go down that path. (CW6) And if, you know, from higher up, they said, ‘No, actually this is now gonna be part of your role. This is what you’re gonna be doing’. Then you, you fit, you make, you, you make it work and you do it. But it would have to be, that’s what they’re wanting the, the OTs to be doing ... (CW5)... In their job description ... (CW3)

Another anticipated challenge was the willingness, or rather energy, for families to participate with the program. The staff felt that families are often exhausted by the time someone is moved to RAC and may be expecting that they no longer need to attend to the care needs of the residents.

So in my experience, I’ve found that some family members have just in a way, like, you know, ‘I’m exhausted, I’ve had enough here. They, they’re yours [to look after now]’.

(CW1)

Regardless of the challenges identified, the staff were optimistic about the program and saw the value it could bring not just for residents, but families and RAC staff as well.

It just sounds like this program would, to me, benefit the families ... Probably more than our residents, just judging on how, yeah, the severity of their dementia. It sounds like if their families can be more educated on how dementia progresses and is as a disease, the more understanding they would be for their, for their loved one, but also for our staff.

(CW3)

3.3 | Therapist impressions and fidelity of delivering the program

Both occupational therapists had been practising and working with people living with dementia for less than 5 years. The therapists completed a self-reported fidelity checklist after their second dyad, each returning one checklist during the study period. Both completed two sessions during assessment phase, implementation was completed over one and three sessions, and generalisation of learned skills was condensed into one session. Most (five and six out of seven) assessments were completed in the assessment component of the program. The therapists addressed either one or two problems and one activity engagement prescriptions within the program (total recommended number is four). All seven steps (problem identification, prescription development, prescription discussion and practice with carer/support person, prescription modelling, prescription revision, and further revision) that were outlined in the intervention manual for 'prescriptions' were completed. Care partner's perceived level of engagement and overall attitude towards the program was rated positively (5/5).

When asked about their experience with implementing COPE (using the DIBQ), both therapists strongly agreed on that they were trained in delivering COPE following the guidelines; they felt confident in delivering COPE following the guidelines and that delivering COPE following the guidelines was pleasurable and interesting. There was more hesitation around items such as 'having necessary resources to deliver COPE' and whether the residents and their care partners were 'motivated'. One therapist reflected:

I just feel like it was the guidelines were clear, um, once I explained it to the carer, it was quite clear what we were doing next and you know, we always had that outline of what was expected at the next session, what they were to practice in between. Yeah, it's just clear for myself and for the participant and the carer.

(OT1)

The therapists reported that applying the program with other RAC staff and Covid-19 restrictions were the major challenges in implementing the program.

... the time we were delivering it, Covid was the biggest, you know inhibitor and that's what really limited you know my ability to go in there face to face for each session and deliver the program.

(OT1)

The therapists also acknowledged that if they worked in the RAC home regularly, delivering the program may have been easier as the other care staff would have been more familiar with them.

I suppose the implementation, I think, uh, is the sort of hardest part, purely just because each time I sort of went there, you know, there was really no recollection [from other staff] at all of who I was.

(OT2)

3.4 | Resident and care partner outcomes and experiences

All five resident participants were in their 80s, and three (60%) were female. All but one care partner were female. Three (60%) dyads were a parent/child relationship, and the other two were spouses.

Responses to the pre- and post-questionnaires for each outcome measure are displayed in Figures S1–S3. The responses related to the resident's activity engagement and QoL were mixed, and one question in each survey was left unanswered as the care partner could not comfortably answer on behalf of the resident. Care partner wellbeing increased from baseline (Figure S2). Of the 13 questions, 10 showed improvement.

Four interviews were completed with family care partners following program completion. The fifth one provided a summary of key impressions over a telephone conversation that was not recorded. None of the residents with dementia engaged in these interviews, regardless this being offered. One family care partner interviewed was not the main person completing the program. The reason for participating in this study was that the families wanted to spend more 'quality time' (CA2) with the resident and to engage them in more activities in the care home. Three themes regarding experiences with the program emerged: 'timing of the program', 'need to engage the care home staff more', and 'ensuring program continuity'. These themes were also discussed in the staff focus group and in the reflections from the intervention therapists.

3.4.1 | Timing of the program

Four of the family care partners talked about the timing of the program and how they wished they could have accessed it sooner after entering RAC. They described how they felt that the family member was 'too far gone' (CA2) to be able to benefit from the program anymore.

If this was in the beginning of [resident's] care home journey, it might have been better.

(CA4)

The family care partners discussed the rapid decline that can happen in a person with dementia's abilities and how crucial even a few months can be with residents in RAC. They described that their family member in RAC may have not understood what the program was about and why the therapist was visiting them.

I don't know how productive the session was with [therapist], and I think gauge—get a pretty good gauge of how [resident] was, et cetera, but from [resident] point-of-view, ... [resident] wouldn't have understood ...

(CA1)

One care partner described how they felt that, in the future, residents in the earlier stages of dementia would be more suitable for taking part in such programs.

I just think you need earlier candidates ... to allow yourselves to benefit and I just think that if you just change the rules a little bit for yourself to be successful.

(CA5)

3.4.2 | Need to engage the care home staff more

The RAC staff involvement was discussed with all care partners. They talked about how important they thought it was to engage and communicate with the RAC staff, including the intervention therapists, on a regular basis. They felt that regular communication between therapists and RAC staff would enable better program implementation and strategies for the resident's care.

I just think there was a- a lack of communication I would say, between, uh, [therapist] and- and the home as to what they would be prepared to implement for [resident].

(CA1)

This was also echoed by the implementation therapists who found it difficult when they were not familiar with other staff members who regularly provided care to the residents.

I think, just because you can have those hallway conversations as well, and feel more fully engaged in it. Whereas it sort of felt as if when you were there, you did what you could for that period of time ... you left, but you don't really know how much that was fully follow-through implemented, you know? Purely with the wide range of, um, carers and ... Just, yeah, I think the engagement there on that side of things was really hard.

(OT2)

One care partner described how engaging other RAC staff, and perhaps educating them about the program, could yield improved outcomes for all, although they recognised that this would need organisational approval.

... in this case, [therapist had] been redirected that information to the staff members ... and then got permission from the organisation to teach the staff ... then, then, then what you do is you just change the rules a little bit and are able to get more than one person [to work with the resident] and that person who maybe you weren't thinking gonna get benefit may indirectly get a benefit from it ...

(CA5)

3.4.3 | Ensuring program continuity

All care partners expressed uncertainty around being able to complete certain program activities with residents, or practising strategies that were discussed with the study therapists.

But the daily routines for activities, so that's the area where I think there's a big gap from what we can do and implement as to what-you know, should happen, to me, that's something that the home should be, um, you know, doing, um, because we're only there a couple or two or three times a week.

(CA1)

The family care partners felt that the onus would also be on RAC homes to ensure that there were other staff available to facilitate the program continuity with residents outside family visiting hours.

TABLE 2 Family carer ratings of the program value

| 1 = not valuable | 1 = not valuable | 2 = somewhat valuable | 3 = valuable | 4 = very valuable |
|----------------------|--|--|-------------------------|--|
| It's no one's fault. | If this was in the beginning of [resident's] care home journey, it might have been better. | It's just we felt like we didn't really have a lot of control. | No additional comments. | 'I think it's very valuable. Anything to do with helping, um, yeah, the people that are in there'. |

It really to me, was more important for the home to- to do ... You know, to agree to do some of these things, which I said, in theory, sounds good, but in practice, it probably won't work.

(CA3)

The families disclosed uncertainty around communication between the intervention therapist and regular RAC staff and thus were unsure how much and what aspects of the program activities could be implemented in the resident's daily schedules.

I just think there was a- a lack of communication I would say, between, uh, [therapist] and- and the home as to what they would be prepared to implement for [resident].

(CA3)

The value of the program as perceived by the care partners ranged from 'not valuable to very valuable' (Table 2). Overall, the family care partners felt that the program may be more valuable if accessed earlier on in the entry to RAC.

4 | DISCUSSION

This paper has discussed a pilot feasibility implementation study of adapting an evidence-based dementia care program, COPE, to RAC setting. We described the changes included in this pilot and the feasibility of the program implementation. The program was designed for use in the community; thus, changes were made to improve fit within RAC home setting, care recipient needs, and to meet with Covid-19 restrictions. We found an acceptable (62.5%) recruitment and excellent (100%) retention rate. The number of sessions and the way they were delivered were the most frequently changed program components and at times did not follow the program protocol sufficiently. RAC staff who took part in the focus group discussion felt that a culture shift is needed for programs such as COPE to be successfully

implemented in RAC setting. The intervention therapists were positive about delivering COPE and how it could work in RAC. The family care partners and intervention therapists felt that these types of programs would be better implemented for residents in early stages of entry to RAC homes or early stages of dementia. Programs such as COPE can be empowering for residents and their care partners, thus ensuring good communication and engaging RAC home staff is important aspect of program delivery and success, and should be the focus of future work.

A recent review of programs that aim to promote independence and activity engagement (i.e., reablement programs) for people in RAC homes found that intervention programs are likely to produce more favourable outcomes if they engage the resident, their family care partners, and care home staff (Rahja et al., 2022). Additionally, organisational factors such as managerial support and care home policies that support reablement are important in ensuring that such programs produce value (Rahja et al., 2022). We also found that involving care home staff and ensuring that organisational arrangements were in place to support the implementation of COPE were crucial. Care home staff play an important role in the lives of care home residents (Royal Commission into Aged Care Quality and Safety, 2021). The traditional approach in RAC homes has been a 'doing for' instead of 'doing with' residents, yet our proposed program focusses on enabling residents to engage in everyday living activities suitable to their level of abilities. Future studies of similar programs should focus on working more closely with care home staff and/or managers to ensure that others involved in a resident's care were familiar with any changes in the way the resident was supported. This could be done, for example, by incorporating care manager handovers in the program delivery, which would facilitate knowledge sharing of the strategies the occupational therapist is practising with the residents and their family care partners. We expect that this approach would help address some of the barriers regarding communication described by families and therapists in our study and ensuring program continuity. From an organisational perspective, several features including culture, leadership, communication, resources,

and evaluation are important features that synergistically support successful implementation of new programs (Li et al., 2018).

A strong message from our findings was that a culture shift was needed for programs such as COPE to be successfully implemented in RAC. Research to date suggests that the current scope of occupational therapy practice in RAC is focused on non-evidence-based activities such as pain and oedema management (Hubbard et al., 2019), and there is currently little evidence to support the core business of occupational therapy (Calderone et al., 2022a).

This study was completed between 2021 and 2022, when the Australian RAC funding was undergoing reform (Commonwealth of Australia, 2023). Until the reform was introduced, services in RAC were influenced by the boundaries and incentives that were linked to the Aged Care Funding Instrument (ACFI). This encouraged outdated care practices (Calderone et al., 2022b), and occupational therapy in RAC was described as a wasted resource (Occupational Therapy Australia, 2019). A new funding scheme, Australian National Aged Care Classification (AN-ACC), is now in place, and it consists of a new assessment tool and method for classifying and funding residents' care that is based on independently assessed care needs (Department of Health and Aged Care, 2022). This is an opportunity to pivot how care and services are delivered by occupational therapists within RAC. Future work in this field will help advocate for occupational therapy and its contribution to the lives of people living with dementia in RAC homes as well as their family care partners. An evaluation should also be conducted to assess if occupational therapy practices in RAC have changed since the introduction of AN-ACC.

Lastly, a prevalent finding was the timing of the program. The family care partners described how they wished they could have accessed the program earlier on in the resident's placement in the care home. Engaging residents and their care partners in programs such as COPE in the beginning of their entry to RAC could be considered in future studies and ongoing implementation. People enter RAC when families can no longer continue support the person live at home safely. The process of placement can be challenging for families (Alzheimer's Australia, 2012), and the care partner role does not stop once a person enters RAC (Jacobson et al., 2015). These families need help, and many have asked for programs that provide social and emotional support, practical advice about how to address changes in behaviours, and opportunities for the resident to participate in everyday living activities. A systematic program, such as COPE, may also help provide structure in the early days of settling to a new routine in a RAC home. Delays in

involving a resident in programs such as COPE may make it harder for them and their care partners to engage as the expectation for what care in the RAC home looks like has already been set.

4.1 | Strengths and limitations

A strength of this study was the use of a well-known framework to record the adaptations made before and during the program to assist with future adaptation and research. The framework was easy to follow, and it provided a more transparent approach to implementing research evidence in practice. Another strength was the use of multiple data collection methods and sources to establish our findings. The findings from the focus group discussion, intervention therapists, and care partner interviews were in agreement and provided comprehensive insights into the feasibility of translating the COPE program into RAC home setting.

Completing the study in one RAC home was a limitation of this study. The study sample was small, and the results cannot be generalised. Covid-19 pandemic and associated restrictions and lockdowns resulted in recruitment challenges and reduced opportunities to visit the care home for both therapists and care partners involved in the study. Covid-19 restrictions also impacted the way the COPE program was delivered and thus required more program adjustments than originally expected. COPE is a dyadic program consisting of the therapist working together with the family care partner and the person living with dementia. However, with some limitations in place, the therapist was not always able to observe the dyad interactions as per program protocol. Another limitation was that the activity engagement and QoL questionnaires focus on a person's everyday engagement in activity, but the care partners may not be present and able to answer these questions accurately due to the small number of visits in the care home in the preceding weeks. This was also commented on by one of the participants in our study. Future studies may wish to consider completing these questionnaires with RAC home staff members instead who may be more familiar with the resident's engagement in activities throughout the days.

4.2 | Implications for research and practice

This study provides several learnings for future research in this field. Programs such as COPE can be implemented in RAC homes, but the implementation requires a

lot of work. Future studies should consider engaging care home staff such as personal carers (who are not directly involved in delivering the program) to ensure program continuity during times when occupational therapists and family care partners are not with the resident. The questionnaires we used to collect dyad specific outcomes appeared suitable, and we received no reports of concern or inappropriateness. Future studies could utilise these questionnaires and use this study as a point of reference.

5 | CONCLUSION

This study has provided valuable information regarding the adaptation and implementation of evidence-based dementia care programs into practice. The program was safe and could be delivered with people living in RAC. Adapting programs such as COPE into RAC fills a major gap in existing services in Australia and promotes evidence-based occupational therapy practice in this setting. While many challenges still exist, knowing that the program can be implemented in RAC is the first step towards including evidence-based programs in service provision. Adaptations to how these programs are implemented in RAC are needed. Using FRAME, we found that most of the adaptations we made were to support feasibility and to meet Covid-19 restrictions. Future studies of COPE, or similar programs in RAC settings, should engage care home staff members in the program implementation. Further program adaptations and further outcome evaluations (related to residents with dementia and their family care partners) are required to assess the program's effectiveness on a larger scale.

CONFLICT OF INTEREST STATEMENT

MR is a current member of the Editorial Board of the Australian Occupational Therapy Journal. The manuscript was managed by the editor-in-chief only, and the journal's peer review processes were followed.

AUTHOR CONTRIBUTIONS

Miia Rahja prepared the study protocol, recruited study participants, interpreted data, and wrote the manuscript. Kate Laver and Maria Crotty engaged in planning study design and provided oversight and guidance. Ann Pietsch and Helen Radoslovich assisted with study design and interpretation of findings. Natalie Galligani and Nicholas Burton collected data and assisted with interpretation of findings. All authors have read and approved the contents of this article and meet the criteria of the International Committee of Medical Journal Editors (ICMJE).

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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REFERENCES

- Albert, S. M., del Castillo-Castaneda, C., Sano, M., Jacobs, D. M., Marder, K., Bell, K., Bylsma, F., Lafleche, G., Brandt, J., Albert, M., & Stern, Y. (1996). Quality of life in patients with Alzheimer's disease as reported by patient proxies. *Journal of the American Geriatrics Society*, 44(11), 1342–1347. <https://doi.org/10.1111/j.1532-5415.1996.tb01405.x>
- Allen, C., Austin, S., David, S., Earhart, C., McCraith, D., & Riska-Williams, L. (2007). *Manual for the Allen cognitive level screen-5 (ACLS-5) and Large Allen cognitive level screen-5 (LACLS-5)*. ACLS and LACLS Committee.
- Alzheimer's Australia. (2012). *The most difficult decision: Dementia and the move into residential aged care*. Alzheimer's Australia NSW.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp0630a>
- Brooks, D., Fielding, E., Beattie, E., Edwards, H., & Hines, S. (2018). Effectiveness of psychosocial interventions on the psychological health and emotional well-being of family carers of people with dementia following residential care placement: A systematic review. *JBIS Database of Systematic Reviews and Implementation Reports*, 16(5), 1240–1268. <https://doi.org/10.1112/jbisrir-2017-003634>
- Calderone, L., Bissett, M., & Molineux, M. (2022a). Occupational therapy in Australian residential aged care facilities: A systematic mapping review. *Australian Occupational Therapy Journal*, 69(5), 625–636. <https://doi.org/10.1111/1440-1630.12824>
- Calderone, L., Bissett, M., & Molineux, M. (2022b). Understanding occupational therapy practice in residential aged care facilities under the aged care funding instrument: A qualitative study. *Australian Occupational Therapy Journal*, 69(4), 447–455. <https://doi.org/10.1111/1440-1630.12805>
- Caughey, G., Lang, C., Bray, S., Moldovan, M., Jorissen, R., Wesselingh, S., & Inacio, M. (2020). International and national quality and safety indicators for aged care. Report for the Royal Commission into Aged Care Quality and Safety, https://agedcare.royalcommission.gov.au/sites/default/files/2020-08/research_paper_8_-_international_and_national_quality_and_safety_indicators_for_aged_care.pdf
- Clemson, L., Laver, K., Jeon, Y.-H., Comans, T., Scanlan, J. N., Rahja, M., Culph, J., Low, L.-F., Day, S., Cations, M., Crotty, M., Kurrle, S., Piersol, C., & Gitlin, L. (2018).

- Implementation of an evidence-based intervention to improve the wellbeing of people with dementia and their carers: Study protocol for 'Care of People with dementia in their Environments (COPE)' in the Australian context. *BMC Geriatrics*, 18(1), 108. <https://doi.org/10.1186/s12877-018-0790-7>
- Clemson, L., Laver, K., Rahja, M., Culph, J., Scanlan, J., Day, S., Comans, T., Jeon, Y.-H., Low, L.-F., Crotty, M., Kurrle, S., Cations, M., Piersol, C., & Gitlin, L. (2020). Implementing a reablement intervention, 'Care of People with dementia in their Environments (COPE)': A hybrid implementation-effectiveness study. *The Gerontologist*, 61, 965–976. <https://doi.org/10.1093/geront/gnaa105>
- Commonwealth of Australia. (2023). Residential aged care funding reform. Department of Health Australia. Retrieved 24 May from <https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/residential-aged-care-funding-reform#:~:text=The%20Australian%20National%20Aged%20Care,what%20we're%20doing%20now>
- Department of Health and Aged Care. (2022). The AN-ACC care funding model. Australian Government. Retrieved 14 July from <https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/residential-aged-care-funding-reform/the-an-acc-care-funding-model>
- Department of Health Australia. (2021). *About residential aged care*. Department of Health. Retrieved 3 November
- Dyer, S. M., Gnanamanickam, E. S., Liu, E., Whitehead, C., & Crotty, M. (2018). Diagnosis of dementia in residential aged care settings in Australia: An opportunity for improvements in quality of care? *Australasian Journal on Ageing*, 37(4), E155–E158. <https://doi.org/10.1111/ajag.12580>
- Edelman, P., Fulton, B. R., Kuhn, D., & Chang, C. H. (2005). A comparison of three methods of measuring dementia-specific quality of life: Perspectives of residents, staff, and observers. *Gerontologist*, 45 Spec No 1(1), 27–36. https://doi.org/10.1093/geront/45.suppl_1.27
- Gitlin, L. N., Winter, L., Dennis, M. P., & Hauck, W. W. (2006). Assessing perceived change in the well-being of family caregivers: Psychometric properties of the perceived change index and response patterns. *American Journal of Alzheimer's Disease & Other Dementias*, 21(5), 304–311. <https://doi.org/10.1177/1533317506292283>
- Gitlin, L., Winter, L., Dennis, M., Hodgson, N., & Hauck, W. (2010). A biobehavioral home-based intervention and the well-being of patients with dementia and their caregivers: The COPE randomized trial. *Journal of the American Medical Association*, 304(9), 983–991. <https://doi.org/10.1001/jama.2010.1253>
- Hayward, J. K., Gould, C., Palluotto, E., Kitson, E., Fisher, E. R., & Spector, A. (2022). Interventions promoting family involvement with care homes following placement of a relative with dementia: A systematic review. *Dementia*, 21(2), 618–647. <https://doi.org/10.1177/14713012211046595>
- Hubbard, I., Mitchelson, K., & Renzi, B. (2019, April). A review of occupational therapists working in residential aged care facilities. *Connections* (pp. 24–25). The Magazine of Occupational Therapy Australia. https://issuu.com/occupational-therapy-australia/docs/ota_connections_april_2019
- Huijg, J. M., Gebhardt, W. A., Dusseldorp, E., Verheijden, M. W., van der Zouwe, N., Middelkoop, B. J. C., & Crone, M. R. (2014). Measuring determinants of implementation behavior: Psychometric properties of a questionnaire based on the theoretical domains framework. *Implementation Science*, 9(1), 33. <https://doi.org/10.1186/1748-5908-9-33>
- Jacobson, J., Gomersall, J. S., Campbell, J., & Hughes, M. (2015). Carers' experiences when the person for whom they have been caring enters a residential aged care facility permanently: A systematic review. *JBIC Database of Systematic Reviews and Implementation Reports*, 13(7), 241–317. <https://doi.org/10.11124/jbisrir-2015-1955>
- King, D. K., Shoup, J. A., Raebel, M. A., Anderson, C. B., Wagner, N. M., Ritzwoller, D. P., & Bender, B. G. (2020). Planning for implementation success using RE-AIM and CFIR frameworks: A qualitative study. *Frontiers in Public Health*, 8, 59. <https://doi.org/10.3389/fpubh.2020.00059>
- Li, S.-A., Jeffs, L., Barwick, M., & Stevens, B. (2018). Organizational contextual features that influence the implementation of evidence-based practices across healthcare settings: A systematic integrative review. *Systematic Reviews*, 7(1), 72. <https://doi.org/10.1186/s13643-018-0734-5>
- Logsdon, R. G., Gibbons, L., McCurry, S. M., & Teri, L. (1999). Quality of life in Alzheimer's disease: Patient and caregiver reports. *Journal of Mental Health and Aging*, 5(1), 21–32. https://www.researchgate.net/publication/232417911_Quality_of_Life_in_Alzheimer's_disease_Patient_and_Caregiver_Reports
- Möhler, R., Renom, A., Renom, H., & Meyer, G. (2018). Personally tailored activities for improving psychosocial outcomes for people with dementia in long-term care. *Cochrane Database of Systematic Reviews*, 2(2), Cd009812. <https://doi.org/10.1002/14651858.CD009812.pub2>
- Occupational Therapy Australia. (2019). *Proposal for a new residential aged care funding model; occupational therapy Australia submission*. Occupational Therapy Australia Limited. Retrieved 26 June from <https://otaus.com.au/publicassets/3a0a6401-3d92-e911-a2c3-9b7af2531dd2/OTA%20submission%20-%20Proposal%20for%20a%20new%20residential%20aged%20care%20funding%20model.pdf>
- OECD Health Statistics. (2021). Long-term care resources and utilisation.
- Rahja, M., Culph, J., Clemson, L., Day, S., & Laver, K. (2020). A second chance: Experiences and outcomes of people with dementia and their families participating in a dementia reablement program. *Brain Impairment*, 21(3), 274–285. <https://doi.org/10.1017/BrImp.2019.34>
- Rahja, M., Laver, K., Whitehead, C., Pietsch, A., Oliver, E., & Crotty, M. (2022). A systematic review and meta-analysis of reablement interventions for people in permanent residential aged care homes. *Age and Ageing*, 51(10), afac208. <https://doi.org/10.1093/ageing/afac208>
- Royal Commission into Aged Care Quality and Safety. (2021). Final report: Care, dignity and respect. <https://agedcare.royalcommission.gov.au/publications/final-report>
- Wiltsey Stirman, S., Baumann, A. A., & Miller, C. J. (2019). The FRAME: An expanded framework for reporting adaptations and modifications to evidence-based interventions. *Implementation Science*, 14(1), 58. <https://doi.org/10.1186/s13012-019-0898-y>

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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